

**POWER, MANAGEMENT AND COMPLEXITY IN THE NHS: A  
FOUCAULDIAN PERSPECTIVE**

**JEAN ISABEL MATTHEWS**

A submission presented in partial fulfilment of the requirements of the  
University of Glamorgan for the Degree of Doctor of Philosophy

February 2009

# Power, Management and Complexity in the NHS: A Foucauldian Perspective

Table of Contents	Page No.
Declaration .....	x
Acknowledgements .....	xi
Abstract .....	xii
Acronyms .....	xiii
Glossary of terms .....	xiv
Chapter One: An Introduction to the Thesis – <i>Mission Impossible</i> .....	1
<b>Introducing the Thesis</b> .....	2
<b>Physician Heal Thyself – <i>The Agony and the Ecstasy</i></b> .....	3
<b>Prescriptions for Change – <i>Modern Times</i></b> .....	5
<b>Defining the Problem – <i>What’s Up Doc!</i></b> .....	7
<b>At Home in the NHS: An Alternative Reality – <i>M.A.S.H.</i></b> .....	8
<b>Researcher Ambitions – <i>Great Expectations</i></b> .....	10
<b>The Structure of the Thesis – <i>Murder on the Orient Express</i></b> .....	11
<b>Tales from the Silver Screen – <i>The Last Picture Show</i></b> .....	15
<b>Chapter Summary</b> .....	16
Chapter Two: Exploring the Discursive Landscape of Health Care – <i>The Good, the Bad and the Ugly</i> .....	17
<b>Introducing the Hyperreality of the NHS - <i>The Matrix</i></b> .....	18
<b>The Political Surface of Health Care Discourse – <i>All the Presidents Men</i></b> .....	21
The Evolution of British Health Care Policy – <i>A Jewel in the Crown</i> .....	22
The NHS in Wales – <i>The Doctor and the Devils</i> .....	27
Political Statements of Health Care in Wales – <i>Enter the Dragon</i> .....	28
A Quality Framework of Governance – <i>Dead Ringers</i> .....	33
<b>Discourses Surfacing from a Managerial Field – <i>How the West was Won</i></b> .....	36

Exploring Managerialism in the NHS – <i>El Dorado</i> .....	37
The ‘Opposition’ of Efficiency and Effectiveness	
– <i>Keep on Running</i> .....	39
Managerialism as a Rational Discourse – <i>The Ladykillers</i> .....	41
Managerialism as a Scientific Discourse – <i>9 to 5</i> .....	42
The Notion of Agent Commitment – <i>The Three Musketeers</i> .....	44
<b>Discourses Surfacing in the Field Of Nursing – <i>Carry on Matron</i></b> .....	47
An Historically Constituted Discourse – <i>The Lady with the</i>	
<i>Lamp</i> .....	47
The Notion of Caring- <i>Misery</i> .....	48
Exploring the Subordination of Nursing – <i>The Stepford Wives</i> .....	51
Nurses in Health Care Management – <i>La Belle et La Bête</i> .....	52
<b>Discourses Surfacing in the Field of Medicine – <i>Doctor in the</i></b>	
<b><i>House</i></b> .....	55
The Historical Emergence of a Medical Discourse – <i>Hearts and</i>	
<i>Minds</i> .....	56
The Emergence of Specialist Knowledge – <i>Look Who’s Talking</i> .....	57
Modernising Medicine – <i>Dr. No</i> .....	58
The Perception of Doctor-Manager Conflict – <i>Star Wars</i> .....	61
<b>Portraits of the Participating Context – <i>Sliding Doors</i></b> .....	62
The Trust’s Public Image – <i>The Godfather</i> .....	63
The Participant’s Perspective – <i>How Green was My Valley</i> .....	64
The Author’s Perspective – <i>For Your Eyes Only</i> .....	66
<b>Conclusion to the Chapter</b> .....	68
Chapter Three:     Moving Beyond Modernism – <i>The</i>	
<i>Forbidden Kingdom</i> .....	70
<b>Introducing the Chapter</b> .....	71
<b>Defining the Notion of Social Order – <i>The Dirty Dozen</i></b> .....	72
The Underpinning Ontology of Managerialism – <i>Gremlins</i> .....	74
The Epistemic Constitution of Agency in Managerialism – <i>Invasion</i>	
<i>of the Body Snatchers</i> .....	76
Exploring the Ontology of Self in Managerialism – <i>Pinocchio</i> .....	77
Midway on the Realist Continuum – <i>Frankenstein</i> .....	79

Summary .....	81
<b>Exploring an Alternative Paradigm of Social Order – <i>Alice in Wonderland</i></b> .....	82
Restoring the Dynamic Ontology – <i>Carousel</i> .....	83
Complexity, Self-organisation and the Importance of Noise – <i>Butch Cassidy and the Sundance Kid</i> .....	85
The Concept of Complex Adaptive Systems Thinking – <i>The Italian Job</i> .....	88
(Re)opening Systems to Co-evolution - <i>2001: A Space Odyssey</i> .....	90
Human Systems as a Complex Adaptive System – <i>Pirates of the Caribbean</i> .....	91
Complexity in a Business Context – <i>Mutiny of the Bounty</i> .....	93
Did Gerry have the Right Idea in the NHS? – <i>Die Another Day</i> .....	96
Summary .....	97
<b>Viewing Complexity through a Post-structural Lens – <i>The French Connection</i></b> .....	98
The Affinity of Complexity and a Post-structural Discourse – <i>A Beautiful Mind</i> .....	99
A Critique of Post-structural Critique – <i>The Man Who Fell to Earth</i> .....	101
Destroying the Notion of ‘I’ – <i>Fight Club</i> .....	102
Habitus as a Fractal Conceptualisation of Self – <i>An American Werewolf in London</i> .....	104
The Relativity of Language – <i>Lost in Translation</i> .....	105
Summary .....	107
<b>The Discursive Constitution of a Complex Evolving System – <i>Go</i></b> .....	108
Understanding the Nature of Discourse – <i>Patriot Games</i> .....	109
Revisiting the Epistemic Constitution of Self through Discourse – <i>The Bourne Identity</i> .....	110
Understanding Discursive Practice as a Complex Adaptive System – <i>Kaleidoscope</i> .....	112
Discursive Practice Creating an Edge of Chaos Ontology – <i>Sixth Sense</i> .....	113
<b>Conclusion to the Chapter</b> .....	114

Chapter Four: Magical Expressions of Power – <i>Monsters</i>	
<i>Inc.</i> .....	117
<b>Introducing the Chapter</b> .....	118
<b>Realist Conceptions of Power – <i>Animal Farm</i></b> .....	120
Dichotomies of Power – <i>The King and I</i> .....	120
Discursive Power: Ideological Notions of Control – <i>My Fair Lady</i> .....	123
Ideology in Organisational Management – <i>La Dolce Vita</i> .....	127
The Limitations of Ideology – <i>Brave New World</i> .....	128
Summary .....	130
<b>An Exploration of the Power Effects of Language – <i>Look Who’s</i></b>	
<b><i>Talking Now</i></b> .....	130
Language as a Strategic Exercise of Power – <i>The Mission</i> .....	131
The Power of the Speaker – <i>The Great Dictator</i> .....	134
Consolidating Truth as Text – <i>The Greatest Story Ever Told</i> .....	136
The Language of Managerialism – <i>Doctor in Distress</i> .....	138
Summary .....	141
<b>A Complex Adaptive Systems Perspective of Power – <i>Batman: The</i></b>	
<b><i>Dark Knight</i></b> .....	142
Foucault’s Amorphous Perspective of Discursive Power – <i>The Karate Kid</i> .....	143
The Foucauldian Concept of Power/Knowledge – <i>The Terminator</i> .....	145
A Productive Connotation of Power – <i>Total Recall</i> .....	148
<b>Invisible Mechanisms of Power- <i>The Wrong Trousers</i></b> .....	148
Technologies of Hierarchical Observation – <i>Someone to Watch Over Me</i> .....	150
Creating the Docile Body – <i>Coma</i> .....	151
Agent Conformance through Examination – <i>Terminator 2: Judgement Day</i> .....	153
The Necessity of Documentation – <i>Spies Like Us</i> .....	154
Summary .....	155

<b>Revealing the Microphysics of Power in NHS Discourse - 1984</b> .....	155
Discourses of Hierarchical Gaze – <i>Room With a View</i> .....	156
Creating the Docile Clinician – <i>Robocop</i> .....	157
Examining Secondary Care – <i>Please Sir</i> .....	161
The Power- Trust Dilemma in Health Care – <i>Blind Faith</i> .....	162
<b>Conclusion to the Chapter</b> .....	164
Chapter Five:    Crafting a Methodological Framework –	
<i>Close Encounters of the Third Kind</i> .....	167
<b>Introducing the Chapter</b> .....	168
<b>Recognising the Dimensions of Knowledge – <i>The Name of the Rose</i></b> ...170	
The Value of Knowledge – <i>The Others</i> .....	170
The Necessity of Phronetic Inquiry in Management Research	
– <i>Bicentennial Man</i> .....	172
The Limitations of Objective Epistemology – <i>Memento</i> .....	174
Researching on Shifting Sands – <i>K-Pax</i> .....	175
<b>Critical Inquiry – <i>The Great Escape</i></b> .....	177
The Logic of Critical Inquiry – <i>Good Morning Vietnam</i> .....	178
Critical Approaches in Management Research– <i>Chance of</i>	
<i>a Lifetime</i> .....	179
Devising a Discursive Analytical Framework – <i>What Lies</i>	
<i>Beneath</i> .....	181
Post-structural Discursive Exploration – <i>The Return of the</i>	
<i>Pink Panther</i> .....	182
<b>Post-structural Reflexivity and Re-framing Validity – <i>Little Voice</i></b> ....185	
The Epistemic Imperative of Reflexivity – <i>Alice Through the</i>	
<i>Looking Glass</i> .....	185
Re-conceptualising Validity in Reflexive Research – <i>Dances</i>	
<i>With Wolves</i> .....	187
Exploring the Author’s Habitus – <i>Basic Instinct</i> .....	188
<b>Negotiating a Method – <i>Brief Encounter</i></b> .....	192
Accommodating Contextual Sensitivities – <i>Don’t Look Now</i> .....	192
The Nature of Stories – <i>Pulp Fiction</i> .....	195
The Intricacy of the Story and Self – <i>True Lies</i> .....	197

The Power Within Stories – <i>Being John Malkavich</i> .....	199
<b>Structuring the Interview Process – <i>Back to the Future</i></b> .....	200
The Biographical Interview Method – <i>The Life of Brian</i> .....	200
Devising the Questions – <i>Once Upon a Time in the West</i> .....	202
Casting the Actors – <i>A Few Good Men</i> .....	204
Writing and the Impossibility of Representation – <i>Dumb and Dumber</i> .....	205
<b>Conclusion to the Chapter</b> .....	207
Chapter Six: (Re)presenting and Exploring the Findings – <i>Snow White and the Seven Dwarfs</i> .....	209
<b>Introducing the Chapter</b> .....	210
<b>Meeting the Cast – <i>The Canterbury Tales</i></b> .....	212
The Ward Manager’s Tale – <i>The Green Mile</i> .....	212
The Sister’s Tale – <i>Mary Poppins</i> .....	216
The Directorate Manager’s Tale – <i>Rebel Without a Cause</i> .....	220
The Senior Manager’s Tale – <i>Star Trek: The Next Generation</i> .....	223
The Clinical Governance Manager’s Tale – <i>Miss Marple     Investigates</i> .....	225
The Intermediate Care Manager’s Tale – <i>The Negotiator</i> .....	228
The Consultant’s Tale – <i>Ghandi</i> .....	231
The Medical Director’s Tale – <i>Top Gun</i> .....	233
Summary .....	235
<b>Exploring the Corporate Discourse – <i>The Magnificent Seven</i></b> .....	236
The Chief Executive’s Report – <i>Nero</i> .....	237
The Review of Performance Management – <i>Chariots of Fire</i> .....	238
The Finance Director’s Report – <i>A Fistful of Dollars</i> .....	239
The Human Resource Director’s Report – <i>In Sickness and In     Health</i> .....	240
The Director of Nursing Report – <i>Ooo Matron!</i> .....	241
The Medical Director’s Report – <i>Doctor in Charge</i> .....	243
The Reports of the Sub-committees – <i>Trains, Planes and     Automobiles</i> .....	243
Summary .....	244

<b>The Inter-Discursive Tangle of Health Care Reality – <i>Body and Soul</i></b> .....	244
The Impact of Political Discourse – <i>On Her Majesty’s Secret Service</i> .....	245
Targets and the Treasury – <i>For a Few Dollars More</i> .....	245
Public Scrutiny of Political Voice – <i>The English Patient</i> .....	251
The Marginalisation of the Management Voice – <i>The Whisperers</i> .....	254
A Discourse of Litigation – <i>Catch 22</i> .....	255
Summary .....	256
<b>The Impact of the Discourse of Managerialism – <i>War Games</i></b> .....	257
Chiefs and Indians – <i>The Towering Inferno</i> .....	257
Opposing the Normative Discourse of Management – <i>Tootsie</i> .....	262
Reconstituting the Service through a Scientific Discourse – <i>Dr Jekyll and Mr Hyde</i> .....	266
Discourses of Performance Management – <i>Bend It Like Beckham</i> .....	271
Summary .....	274
<b>The Impact of Clinical Governance – <i>The Odd Couple</i></b> .....	275
The Scientisation of a Caring Discourse – <i>The Graduate</i> .....	275
The Standardisation of the Complex Patient – <i>Blade Runner</i> .....	277
Discourse of Surveillance as Risk Management – <i>Panic Room</i> .....	280
Processes of Accountability – <i>The Producers</i> .....	282
Summary .....	285
<b>Relating the Findings to the Research Themes – <i>The Full Monty</i></b> .....	286
Revealing the Extent of Discursive Closure - <i>Equilibrium</i> .....	286
The Discursive (Re)constitution of Self – <i>Face Off</i> .....	287
The Resilience of Self – <i>The Empire Strikes Back</i> .....	288
The Discursive Impact on the Context as a CES – <i>Snakes on a Plane</i> .....	292
The Discursive Boundaries to Co-evolution - <i>Braveheart</i> .....	293
<b>Conclusion to the Chapter – <i>Flight of the Phoenix</i></b> .....	294



Chapter Seven: The End of a Beginning – <i>The Morning After</i> .....	298
<b>Introducing the Final Chapter</b> .....	299
<b>Reflecting on the Aims of the Research – <i>High Noon</i></b> .....	301
<b>The Necessity of Moving Beyond Modernism – <i>Ghostbusters</i></b> .....	304
<b>Thoughts for Future Research – <i>Never Say Never Again</i></b> .....	308
<b>Reflecting on the Theoretical Framework to this Thesis – <i>Look Back in Anger</i></b> .....	309
<b>Validating the Methodological Approach for My Context – <i>Shadow of Doubt</i></b> .....	312
<b>Reconstituting the Researcher’s Self – <i>The Bride of Frankenstein</i></b> .....	314
<b>Final Comment – <i>Never Say Goodbye</i></b> .....	318
<b>References</b> .....	320
<b>Appendices</b>	
Appendix I: The Literature Review Pathway.....	378
Appendix II: The Letter of Approach .....	379
Appendix II: The Participant Information Leaflet .....	380
Appendix III: The Participant Consent Form.....	382
Appendix IV: The Researcher’s Post Interview Reflections .....	383
Appendix V: Interview Transcripts and Trust Board Minutes.....	CD

### **Declaration**

I certify that this work is my own work and that appropriate reference has been made to the work of others where appropriate. This work has not been submitted for any other degree.

Signed.....

Date.....

## Acknowledgements – *The Oscars...the nominations are*

There can never be just one producer of a work of such proportions and thus my thesis presents a co-evolution of ideations, suppositions and hypotheses and I am merely one of many voices who have been intimately involved in its composition. Where would I have been without the profundity and criticality of Michel Foucault, Jacques Derrida and Pierre Bourdieu, to name but a few and whose contribution to this work has been vast and without whom we would all remain cerebrally shallow.

To their insights I add the scholarly conjecture of the Complexity thinkers whose alternative conceptions of evolutionary existence radically challenge the dominant understanding of social existence and management ‘science’. I feel humble following in their footsteps and trust my work contributes to their unfolding discipline.

There can only be one nomination for the Best Director award, my Director of Studies, Paul Thomas, who encouraged me to undertake this research and has supported me throughout. In common with the many academics with whom I have had the pleasure to interact in the course of this thesis, Paul’s boundless knowledge, energy and passion for his subject and his beliefs is inspirational and infectious.

Of course, this thesis would not have been possible without my leading actors and actresses and I thank all the managers and clinicians who willingly gave me their hospitality within their busy schedules for what must have appeared as a perplexingly unconventional interview. Their stories have left an indelible imprint on my self and encourage me to continue with my studies to further emancipate the voices of those to whom this thesis is dedicated; the NHS and all those who serve its interests.

There is only one nomination for the Best Supporting Actor and this undoubtedly goes to my husband, Rob, whose love and endless support has made this PhD possible. There have also been countless friends and relatives who have supported me through this study and not complained at my neglect, but the Best Supporting Actress award can only go to Lynda Pinnell whose close friendship I have enjoyed for almost thirty years and whose interest in this project, even through the most difficult and emotional of times, has been unstinting

## Abstract – *What's New Pussycat?*

This thesis is a critical and post-structural exploration of the discourse of managerialism in the NHS secondary care sector in Wales. Its central intent is to destabilise the dominant thinking about NHS management practice and to evoke intellectual debate about alternative discourses of management that ontologically perceive the organisation as a complex adaptive human system. The emergent theoretical framework conjoins the discipline of Complexity with post-structural conjecture, posing a novel conceptualisation of a fractal self where relations of power are seen as essential for harmonising diverse influences and legitimising a local discourse that informs and regulates practice. Using Foucault's insights on power and knowledge the thesis critiques the strategic nature of NHS discourse, exposing the discursive dominance of managerialism and its inherent relations of power and debates what this predicates for a local negotiation and a flexible, safe and innovative environment. The methodological approach employs a reflexive and micro-level interpretative strategy to emphasise the singularity of agents and to explore the way in which the discursive constitution of the self influences agent practice. My profound experience of the secondary care system requires I situate my self reflexively within the context where I explore and liberate my own voice in conjunction with my participants. The research adopts a biographical narrative method of data collection and uses Foucauldian discourse analysis as a framework for exploring the underlying discourse in agent stories. The findings demonstrate the polyphonic nature of the secondary care context and reveal the diverse ways in which agents legitimise, negotiate or resist the conflicting truth claims of various discourse in order to strategically sustain an image of health care historically constituted in their self. The results portray a web of discourses that endorse conformity or complicity through oppressive mechanisms of disciplinary control and surveillance, perpetuating authoritative and dualist structures, dissipating relations of trust and removing intellectual thinking from the front-line. The conclusion asserts that this significantly jeopardises the ability of agents to legitimise local 'discourse', severely limiting their capacity for adaptive practice and the generation of new order.

## Acronyms

BBC	British Broadcasting Company
BMA	British Medical Association
CAS	Complex Adaptive Systems
CBI	Confederation of British Industry
CES	Complex Evolving Systems
CHC	Community Health Council
DToC	Delayed Transfers of Care
DOH	Department of Health
ESR	Electronic Staff Record
EU	European Union
LHB	Local Health Board
GMC	General Medical Council
HIW	Health Inspectorate Wales
IBD	Improvement by Design
KPI	Key Performance Indicators
LDP	Local Delivery Plan
MMC	Modernising Medical Careers
MRSA	Methicillin Resistant <u>Staphylococcus aureus</u>
NAW	National Assembly for Wales
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NLIAH	National Leadership and Innovation Agency for Health
NPM	New Public Management
NPSA	National Patient Safety Organisation
RCN	Royal College of Nursing
SaFF	Service and Financial Framework
SPI	Safer Patient Initiative
SWOT	Strengths, Weaknesses, Opportunities, Threats
TQM	Total Quality Management
UA	Unified Assessment Process
WAG	Welsh Assembly Government

## Glossary of Terms

<b>Acute care</b>	Care for a short term medical condition from which a patient is expected to recover
<b>Applying the Common Seal</b>	Approving or endorsing a document by applying the organisation's logo
<b>Agency and bank staff</b>	A reserve of temporary staff, frequently associated with nursing services, who may be called in to cover shifts. The banks may be run privately or by the NHS
<b>Bed blocker</b>	A patient who is medically fit for discharge but whose discharge is delayed whilst a suitable placement or package of social care can be arranged
<b>Continuing care</b>	Where a patient requires input from a health care professional because of a chronic or long term medical condition
<b>Delayed transfers of care</b>	A patient who is medically fit for discharge but whose discharge is delayed whilst a suitable placement or package of social care can be arranged
<b>Directorate</b>	A directorate is a group of divisions with similar characteristics, eg surgery, medicine.
<b>Division</b>	A specialist area of health care, for example, ear nose and throat surgery.
<b>Local Health Board</b>	An NHS organisation in Wales that is responsible for commissioning the health care needs of its population from primary, secondary care providers
<b>NHS Trust</b>	A self-managing NHS organisation in Wales commissioned to provide secondary care services to a population
<b>Outlier</b>	A patient who is not on the correct ward for their condition, for example a patient with a chest infection on a surgical ward
<b>Pace-making device</b>	An electronic device implanted in the heart to control the heart rate.

<b>Primary care</b>	Primary care services are based in the community, such as GP practices and community based clinics and act as the first point of health care contact for a population
<b>Protocol led discharge</b>	A process where a consultant delegates the responsibility for discharging a patient as medically fit to the nursing team. Patients are assessed as fit for discharge in line with criteria devised by the responsible consultant
<b>Safer Patient Initiative</b>	A programme sponsored by a charitable organisation in the UK, to prevent the unnecessary harm of patients through interventions that aim to improve infection control, minimise errors and improve communication
<b>Second Offer</b>	A process where a patient is sent to another hospital for treatment often to hasten productivity
<b>Secondary care</b>	Health care provided by medical specialists from an NHS Trust
<b>Service and Financial Framework</b>	A framework that links health care resources with performance and orients around the national priorities laid out by the Welsh Assembly Government. It includes better management, new developments, re-engineering, changes to practice and the ways in which demand and capacity are managed
<b>Sister</b>	A nurse who may have specific responsibilities (managerial or clinical) on a particular ward and who reports to the ward manager
<b>Social care</b>	Any care provided by the social services sector as opposed to the health care sector
<b>Unified Assessment</b>	A single multi-disciplinary process for assessing and managing the ongoing care needs of a patient
<b>Ward manager</b>	The nurse with the overall responsibility for the operational and budgetary management of ward

**Chapter One:**  
**An Introduction to the Thesis**  
*- Mission Impossible*



## Introduction to the Thesis.

*“This world: a monster of energy, without beginning, without end; an immovable, brazen enormity of energy, which does not grow bigger or smaller; which does not expend itself but only transforms itself”* (Nietzsche, 1910).

This thesis is located within the continually changing currents of NHS governance and is written for all those who serve its interests. My use of the word *all* is deliberate as I include my self in this notion of a ‘collective’ unity; my research can never be disengaged from the changing currents of my own NHS experiences. The basis for this post-structural (Derrida, 1976; Foucault, 1972; 1980a) critique is founded on the supposition that managerialism (Boje, 2006b) in the acute secondary care context of health care is counter-intuitive to a flexible, innovative and safe environment.

This introductory chapter aims to present the reader with the background and structure to my critique. In addition to briefly outlining the concerns that emerge from the academic literature on managerialism in the public sector, this chapter draws the themes that guide this inquiry and briefly clarifies why I have integrated unique intellectual perspectives of (anti)management (McMillan, 2004; Mitleton-Kelly, 2003a), power (Foucault, 1972; 1980) and agency (Bourdieu, 1991; 1977; Foucault, 1972; 1979a) in a way that vies with the traditional modernist approach and transforms the mainstream assumptions surrounding the nature of social order.

The central focus of this thesis is to inform and destabilise the dominant thinking about NHS management practice and to stimulate intellectual debate about alternative discourses that appeal to the naturalistic and polyphonic (Clegg, Kornberger and Carter, 2003) nature of the organisation as a human social system. The thesis also contributes to the field of management research by progressing a novel and distinctive theoretical perspective of organisational ontology, and its epistemic constitution, by employing the reflective and provocative thoughts of post-structural philosophers, in particular, the work of Derrida (1976), Foucault (1972, 1980) and Bourdieu (1991). To begin, I start the chapter by revealing my motivation for undertaking this study

“Physician, heal thyself” – *The Agony and the Ecstasy*

This thesis is an exploration into the way in which a pervasive discourse of modernist governance, defined as managerialism, is infusing and influencing NHS agent practice and driving a legitimised way of thinking about the frailties of health care. The context is the acute secondary care sector in Wales, a field of National Health Service (NHS) care with which I am extremely familiar by virtue of my twenty-five years experience as a practising NHS pharmacist and manager.

In part, the impetus emerges from the findings of my earlier research into the NHS secondary care context (Matthews, 2004; Matthews and Thomas 2007; Thomas and Matthews, 2006; Thomas, Liddle and Matthews, forthcoming). My conclusions argue that the authoritative structures and mechanistic processes of managerialism distort naturalistic interactive behaviour, potentially removing the clinical autonomy and ownership that cultivates a natural capacity for reflective and flexible behaviour. However, it is my more recent experiences that inspire this research at an emotive level, motivating a profound desire in myself to expose a discourse of management that I recognise as posing a radical disjuncture with the prevailing philosophy of every day clinical level practice.

Over the past twenty years I encountered, in my position as a departmental manager, a significant shift in the political focus of health care that led to an unprecedented rise in the number and power of NHS managers, tasked with the massification of health care services through a discourse informed by quasi-market competition and performance management. The logic of the government’s proposals appeared sound, as I recognised how rising social expectations and medical advances had stretched the public purse. I concurred with the discursive claims and the stated objectives of reform; to provide more cost effective and timely treatment by relinquishing bureaucratic chains and jettisoning the hierarchical and authoritarian structure to stimulate an organic and entrepreneurial organisation, where performance could meet expectations and innovation flourish (Blackman, 2001; DOH, 1997; Horton, 2003; Hunter, 2003; Pollitt, 2003). Whilst superficially the reforms portrayed an image of

workforce empowerment, the managerialist discourse that ensued, in complete contrast, appeared to marginalise the clinical level voice, generating a significant shift in the relations of power between clinicians and managers (Dent and Whitehead, 2002; Exworthy and Halford, 1999; Gilbert, 2005; Horton, 2003; Rose, 1999).

On a personal level, it is these changing relationships that became the major political incentive behind this thesis; simultaneously acting in a professional and managerial capacity, my 'self' became quickly entangled by a multitude of competing discourses that frustrated my conscious desires for success, both organisational and personal, and raised anxiety by threatening and challenging the legitimacy of my professional commitment. The notion that the focus of clinicians and managers could become so divergent is not only alien to my own dispositions, it was as a departmental manager both costly in time, job satisfaction and staff morale, resulting, as Young (2000) claims, with individuals, myself in particular, "*feeling unimportant and powerless*" (2000:375).

My thesis thus represents a critique of the dominant modernist paradigms informing contemporary healthcare management and introduces a novel philosophical framework to look beyond the modernist belief that system stability predicates social order. I argue for a discourse that can confront ambiguity and instability and integrate not only the diversity of system agents, but also the subjective constitution of self.

Methodologically, my experiences refuse to allow me 'freedom' in the writing of this thesis and I thus navigate a reflexive, exploratory and therapeutic journey, often personal and emotional, as I attempt to explore the multi-dimensional voices of the context and my own self, enabling me to make sense of my own subjective experience, by reflecting on the experiences of others in the secondary health care field.

## Prescriptions for Change - *Modern Times*

The 'post-bureaucratic' restructuring of the NHS, catalysed by the Griffiths' Report (1983) introduced a succession of political initiatives aimed at stimulating a more business-like and entrepreneurial approach (Harrison and Smith, 2003; Kickert, 1997) to the new consumer market of the NHS. However, whilst government rhetoric spoke of a service quality as "*fashioned to meet the individual needs of patients and clients*" (WAG, 2005:1) the underlying order of managerialism privileged the corporate values of efficiency, functionality, accountability and the saliency of management (Bolton, 2002; Cutler and Waine, 2000; Kickert, 1997; Richman and Mercer, 2004; Stacey and Griffin, 2006; Watson, 2002). What became objectified to support this philosophy of management was a *managerial meta-myth* (Adams and Ingersoll, 1990: 285) that supported the delusional reality of the public sector as inefficient and wasteful because of a lack of disciplinary mechanisms and management control (Audit Commission, 2008; WAG, 2005; 2007). Hence, NHS clinicians were introduced to a novel and unfamiliar discourse; *New Public Management* (NPM) (Hood, 1991) a discourse that espoused the central tenets of managerialism, but whose credence is critiqued for denying any public-private sector distinction (Pollitt, 2003), a *lack of ethical content* (Denhardt, 1993: 9), and for seemingly rebuffing any advances in management theory since the reign of F. W. Taylor (Koontz, 1980)

The change in government, in 1997, heralded the *partnership* approach of New Labour (DOH, 1997) informed by Giddens' (1998) model, the *third way*, it was poised to remove the worst excesses of the internal market and its perverse performance management targets. However, in Wales, the devolved government rejected the market economics of the third way (WAG, 2007a) instead proposing a re-centralisation of services, but the central basis of managerialism, as 'professional', rational and scientific (Hood, 1991) remains entrenched.

What must also be acknowledged in this thesis is that managerialism is but one strand of the modernist theme of New Labour governance as, running in parallel, is the discourse of Clinical Governance, a new quality framework that responds to politically-recognised failures of care (Baker, 2000; Whitson, 2000)

and which advocates the streamlining and standardisation of processes and the monitoring of clinical performance through clinical audit (DOH, 1998; Donaldson, 2000; Swage, 2000). Clinical governance legitimises the principles of systematic control and surveillance within the practice of health care complimenting the rational and linear mentality of managerialism (Flynn, 2002; Haynes, 2003; Stacey and Griffin, 2006). As Greener (2006) exclaims, “*the government has found ways to interfere in medical practice on a remarkable scale*” (2006: 660).

Ultimately, the overriding concern is that despite enormous increases in funding these convergent modes of governance are failing to empower staff to deliver the improvements it sought (Doherty, forthcoming; Garside, 2004; Guo, 2004, Hothi, 2004; Pollitt, 2000; Rhodes, 2003, Stacey and Griffin, 2006) and that NHS managers have not been any more influential on NHS performance (Davies and Kirkpatrick, 1995; Harrison and Pollitt, 1994). With regard for the government’s aspirations to generate entrepreneurship, research instead indicates that the current mode of governance is fracturing relationships, distorting statistics, generating silo cultures, low morale and reduced trust (Boden, Cox and Nedeva, 2006; Doherty, forthcoming; Edwards, 2007; Gilbert, 2005; Haynes, 2003; Horton, 2003; Learmonth, 2006a; Pollitt, 2003; Stacey and Griffin, 2006; Young, 2000). Nevertheless, regardless of the growing disquiet and the disparaging remarks from both clinicians and the business academe, health care policy in Wales appears steadfast, fixed within a paradigm based on the primacy of measurement, control, uniformity and functionality (Haynes, 2003; Klein, 2007; Learmonth, 2006a; Learmonth and Harding, 2004; Pollitt, 2000; 2003; Stacey and Griffin, 2006; Timmins; 2007).

The most damning evidence of the shortcomings of managerialism, which although emerging in England, is eminently translatable to Wales, is revealed by the Healthcare Commission (2006; 2007) where patient safety was severely breached because; “...*senior managers...had mistakenly prioritised other objectives, such as the achievement of government targets, the control of finances and the reconfiguration of services*” (2006:1). In this regard, Pusey’s (1991) observation remains disturbingly apposite; “*There is no quarrel with the*

*notion of efficiency as such. The inherent problem lies instead at another level...the loss of social intelligence and with the number and range of conflicting discourses that have been suppressed” (1991:22).*

### Defining the Problem - *What’s up doc!*

A reasonable question that might surface is why managers cannot steer the NHS to success. As McMillan (2004) argues, surely management training provides the necessary hypotheses and tools to enable the right decision to be made at the right time. The rational process of measuring, planning and monitoring ought to enable managers to stay in control, but *control* is a nebulous concept. What is control and what is it attempting to achieve? Grey (2005) believes that the dilemma begins “*when organisations are simply thought about it in terms of ‘getting the job done’ it cuts out so much that matters – who says what the job is, who says how it should be done and how are people affected by doing it this way” (2005:3).*

A managerialist philosophy generates the notion that organisational order ceases to be pre-ordained and is the arena for management intervention and control and is based on the fundamental assumption that systems are controllable and should be controlled (Grey 1996). This results in a machine-like perspective of the organisation and a partiality for cybernetic and ideological philosophies of management (Griffin and Stacey, 2006; McMillan, 2004; 2008; Watson, 2002) positioned to linearly design and engineer the health care system towards the visionary future state (Streatfield, 2001) of politicians.

This notion of order attempts to reify boundaries to enable a stable and closed system. Reification aims to transform an abstract concept into a concrete artefact and fails to recognise the ontological reality; the healthcare context as a messy and complex pattern of clustered human relationships, a social system under the impact of an abundance of political interference, public and ethical scrutiny and symbolic significance (Boyne, 2002; Haynes, 2003; Streatfield, 2001); a plexus of multifarious discourses with which the organisation must and does interact. It is common sense that if people are treated like cogs in a machine they will not give loyalty and trust (Lewin and Regine, 1999) but the contemporary idealised

notion of rational strategic management, *with its peculiar and particular discourse* is limiting the government's capacity to imagine any alternative form of organising (Parker, 2002).

Managers are not professional philosophers or sociologists, but management theory is grounded in ontological and epistemological perspectives informed by such time-honoured disciplines. However, I surmise that whilst philosophical and sociological debates evolve, management practice, in the public sector, seems to be regressing into the mechanistic and scientific paradigm that emerged almost a century ago and I suggest that any discipline that attempts intellectual closure about the characteristics of human behaviour will consequently limit what it can know, by constraining what it will ask (Stacey and Griffin, 2006). Discourses of rational strategic management do make for powerful arguments about the predictable aspects of organisational life (Stacey and Griffin, 2006), but no amount of rationality and reductionism can determine, in advance, what human behaviour and interaction will be in order to determine specific outcomes (Parker 2002).

Currently, the government's prescriptive policies are not corresponding with the unplanned and unpredicted way the acute healthcare organisation is changing and this critical inquiry aims to communicate an alternative orientation of the organisation, exposing the assumptions on which modernist modes of governance are founded and revealing how managerialism seeks to not only physically control, but applies oppressive mechanisms of power that drive into the very 'soul' of professional values (Clarke and Newman, 1997; Dent and Whitehead, 2002; du Gay, 1996; Garside, 2004)

### *At Home in the NHS: An Alternative Reality - M.A.S.H.*

To synergise my thinking through new lenses, this thesis merges theoretical insights from the disciplines of Management, Complexity and Sociology allowing me to challenge the need, or indeed the ability to regulate and monitor agency through a prescriptive discourse that designs and directs practice. My exploration of these disciplines reveals a considerable overlap, each providing a substrate that elucidates the ambiguous and contradictory nature of human

agency, crucial for elaborating on the effectiveness of any management discourse.

So, how do I expect a novel post-structural framework to advance theory and clarify the way in which one philosophically views the secondary care system? With organisations throughout the world, attempting to become less hierarchical and more de-centralised in the hope of increasing flexibility and competitive advantage, I found the thoughts of Kauffman (1995) in *At Home in the Universe* provides an influential and persuasive source of inspiration, as it offers profound insights for mainstream management theory. Kauffman (1995) argues that mainstream theory lacks the fundamental know-how about *how* to de-centralise management practice and Kauffman and his colleagues from the Santa Fe Institute in New Mexico propose an alternative theoretical frame of reference, Complex Adaptive Systems (CAS) thinking, to take management beyond the systems thinking model, as they translate novel ontological perspectives of biological and physical systems into the practical problems of business and management. Kauffman's analogy is meaningful for those who cannot comprehend, let alone address the reality of organisational ontology; "*No molecule in the bacterium E.coli 'knows' the world E.coli lives in, yet E.coli makes its way*" (Kauffman, 1995: 246). No single person in the NHS, knows the world of secondary care and yet, collectively secondary care acts. Kauffman continues *...there is more of the 'blind watchmaker' at work than we usually recognise* (Kauffman 1995: 246)

Kauffman's insights allow us to surrender the traditional view of power relations that managerialism sustains, re-conceptualising the organisation not in dichotomous terms but as a dynamic human web of relations that naturally and spontaneously responds and adapts to their highly charged and emotive environment, through the innate characteristics of connectivity, interdependency, reciprocity and heterogeneity (Mitleton-Kelly, 2003). Reflective of the inherent sociality, it is a framework that when synthesised to human social systems can preserve the sentient nature of agents; agents with desires, volition and voice and a uniqueness of self that echoes their personal history (Bourdieu, 1991; Dreyfus and Rabinow, 1986; Foucault, 1988).



The rhetoric of government is curiously paradoxical in its acknowledgement of the highly agent-based nature of the health care context, contending; “*An increasing separation between policy and delivery has acted as a barrier to involving in policy making those people who are responsible for delivering results at the front line*” (Cabinet Office 1999: Section 2:4), but continues to advocate an approach to health care counter-intuitive to this micro-level organicity. What is essential to emphasis at this point however is that I do not propose to apply the framework of Complexity as an alternative *in vitro* ontology, but argue that Complexity already exists *in vivo*, hidden under the layers of traditionalist management control.

Health care across the UK is struggling; there has been a tremendous shift in the organisational landscape, culminating in two antithetical philosophies, existing concurrently, striving to operate within the same system. It is thus the purpose of this thesis to advance a new ontological and epistemic perspective and to stimulate management thinking and practice in a way that accepts that control is not only futile, but in danger of removing an agent’s ability to evolve and co-evolve practice. The application of Complex Adaptive Systems thinking is not novel in the discipline of contemporary sociology, but its synthesis into management circles has been more reticent. Novel paradigmatic orientations of organisational life may perturb those who adhere to mainstream management theory, but the implications of the Complexity perspective is impossible to ignore; no one paradigm can say it all.

### Researcher Ambitions - *Great Expectations*

This thesis re-conceptualises the secondary health care context through a Complexity lens by formulating a unique theoretical and analytical framework that aligns with a post-structural and discursive ontology of human social systems. The framework evokes an original way of thinking about organisational behaviour and relations of power in a way that celebrates the polyphonic vocality of the context and the subjective nature of agent interpretation and argues that this plurality is a crucial dimension to stimulate transformational capability.

The research is informed by the following themes that focus on the socio-political aspects of discourse (Foucault, 1972) and explores of the strategic relationship by which secondary health care is defined, examining the relationships between discourse, knowledge, self and power.

- i. Do mechanisms of power exercised through managerialism attempt to maintain discursive closure in favour of a particular reality of secondary care.
- ii. In what way does the reality presented by the discourse of managerialism impact on the inter-discursive constitution of an agent's self.
- iii. Does the context reveal the existence of competing, dominant and marginalized discourses at the micro-level; in what ways are these legitimised, tolerated or resisted by agents and to what extent does this impact on their practice.

The research does not aim to express findings in a didactic manner, but aims to rouse scholarly dialogue by proposing alternative perspectives of organisational order and agency. It aims to debate whether dominant discourses of NHS governance constrain agent autonomy and plurality and distort or distract practice.

### The Structure of the Thesis – *Murder on the Orient Express*

In some ways I feel I am writing this thesis as if a 'murder mystery'. Although my writing follows the conventional, linear and formal 'big book' structure, to provide clarity for the reader, I feel the 'plot' unfolds as the chapters' progress, each revealing snippets of 'new' knowledge that adds to the finalé. This thesis is a living document that follows my progress through the various stages of my study from perhaps, its naïve beginnings to its critical closure.

As in any 'novel', a symbiotic interaction between reader and author may also be generated, where some readers may connect at a deeper level with the author's self or those of my respondents. You may consider you recognise your

‘self’ within this work and I am confident that you will add another dimension as you raise your voice either in support or opposition of my respondents’ tales.

Post-structuralist writing strives to be provocative and evocative (Miller, 2006) and I do seek to influence your thinking by challenging the assumptions and boundaries of health care reality, by exposing the partiality of discursive constructs and by appealing to your own desires and imagination. Miller (2006) also suggests that, as a post-structuralist, I overturn the seriousness of academic work by introducing playful analogies and thoughts, although I stress this does not intend to undermine the seriousness of my work.

**Chapter Two** follows this introduction and draws from Foucault’s (1972) text, *The Archaeology of Knowledge*, to explore the discursive backdrop to this research, describing and revealing, through Foucauldian *archaeology*, the discursively constituted nature of my secondary care context. My use of the terms ‘discourse’ and ‘discursive’ are pervasive throughout my thesis. Discourse relates to the Foucauldian conception of discourse as; “*statements and utterances grouped together through regular, often contextual, association within a social system*” (Foucault, 1972:80). Foucault (1972) contends that the self is (re)constituted by the truth claims within the discursive field and this, in turn, influences agent practice; termed discursive practice.

The chapter identifies the discursive unities that inform and differentiate each field of healthcare into medicine, nursing, politics and management and discloses a historically constituted and legitimised ‘meta-discourse’ in each field; a dominant representation with which members reflect and are expected to conform. The chapter also reflects on the deficiencies of viewing any context through a single lens and concludes with a multi-voiced portrayal of the study context.

**Chapter Three** is the search for an intellectual framework that looks beyond the assumptions of mainstream management theory for one that can embrace the ambiguity, instability, plurality and emotion innate in a complex human social system, one that can integrate not only the diversity of agents, but also, more

significantly, the diversity of selves. The chapter draws from a body of knowledge that neighbours the discipline of management, contemporary sociology, as I raise ontological and epistemological questions regarding the assumptions of realist paradigms associated with modernist discourses of management.

In generating a more fluid and diachronic model of the organisation I integrate insights from Complexity Theory with the conjecture of contemporary post-structural social theorists. My thinking moves away from the scientific theories of Complexity towards frameworks that evoke a deeper understanding of agency at the micro-level of human systems and primacy is given to Mitleton-Kelly's (1998; 2003a) concept of Complex Evolving Systems (CES). Mitleton-Kelly's work is significant in explaining how the human characteristics of learning and memory impact on agency and the direction of system evolution.

In the post-structural literature I focus on the thoughts of Foucault (1972), Derrida (1967) and Bourdieu (1977, 1991), whose convergent and relativist concepts of human systems as discursive constructs, language, self and agent *habitus*, whilst emerging in parallel to Complexity, mirror the temporal, emergent and subjective characteristics of the CES. Their philosophical standpoints similarly portray a novel micro-perspective of 'agency and 'social order' and provide a deeper epistemological understanding of self-organisation and emergence in a CES and the discursive conditions that promote or stifle these essential characteristics.

As a major focus of this work **Chapter Four** is dedicated to a re-conceptualisation of power and builds on my archaeological exposé, in chapter two. Applying Foucault's insights on power/knowledge to the CES, the chapter ponders on how discourse and discursive closure can influence agency and social order and thus radically impact on the processes of self-organisation and co-evolution. Within the chapter, I critique how dominant realist perspectives of power limit management thinking and argue that Foucault's (1972, 1980) post-structural and productive perspective of power, as exercised through agency, offers a persuasive and coherent challenge to managerialism. The chapter

concludes by exposing the relations and dynamics of power in the two major governing discourses of NHS discourse, managerialism and clinical governance, and ponders what this might predicate for clinically legitimised practice.

**Chapter Five** turns attention to the construction of a critical methodological approach that is consistent with my objectives and my preferred philosophical position and challenges the paradigmatic dominance of modernist knowledge in management discourse. Consistent with my post-structural thinking, I explain why my methodology requires a micro-level interpretive approach that emphasises the singularity and uniqueness of each participant, but which can unearth the competing discourses and the way in which they are resisted, tolerated or legitimised. Seeing the organisation as a multi-vocal construct, I extend the use of a biographical-narrative method into the healthcare context and incorporate Foucauldian discourse analysis as a framework for analysis. Acknowledging that epistemological relativism recognizes that knowledge is not an *a priori* phenomenon but is intimately bound to the self (Davies, 1999) my chosen method allows me to I situate my self reflexively within the context allowing me to explore and liberate my own voice in conjunction with my participant others.

**Chapter Six** presents the findings of the study and raises the multiplicity and uniqueness of voices of those who work in the secondary health care system. As a reflexive analysis, the interpretations are provisional and contextually situated but seek, as Lincoln and Guba (2003) so eloquently express;

*“to portray the contradiction and truth of human experience, to break the rules in the service of showing, even partially, how real human beings cope with both the eternal verities of human existence and the daily irritations and tragedies of living that existence”* (2003:285)

The chapter also deconstructs the underpinning discourse that dominates the statements of the Trust Board and concludes with a thematic interpretation of the discursive reality of the secondary care context asking what this may mean for an organisation as a CES.

The final chapter, **Chapter Seven** provides a degree of closure to this thesis, by summarising the significance of its findings in relation to its three key themes. I reflect on how my findings advance the scholarly debate regarding dominant paradigms of management practice and pose ideas for future research and critique. I also contemplate my assumptions and the limitations of my philosophical and methodological frames of reference in meeting my research objectives. As a reflexive study that incorporates my own voice and experiences alongside those of my respondents the chapter reflects on the journey my self has made over the past four years and whether it has been successful in healing or appeasing the ‘physician’ self.

### Tales from the Silver Screen - *The Last Picture Show*

*“Cinema is the most beautiful fraud in the world”*

(Jean-Luc Goddard)

I am no media scholar, or film buff, far from it, but throughout the dissertation I analogise concepts and ideas with images and metaphors from the world of cinematography. As a post-structuralist this parallel thinking attempts to appeal to the reader’s imagination, conjuring images to evoke particular sentiments. The mischievous and well-intentioned subtitles or subtexts hope to produce a little light relief for the reader, as it certainly made its construction from my point of view more pleasurable, but on a more serious note I see two fundamental reasons why the film industry has an affinity with management.

Firstly, I see the analogy of the manager as a film director and his workforce, the cast. Like a director, the Chief Executive believes himself a virtuoso, a visionary, almost egotistical in his desire to synthesise his uniqueness and personality onto an organisation; it is his film set. The director’s omnipresence is explicit in his adaptation and interpretation of the script, he becomes the *auteur*, a term that reflects how the director’s re-interpretation re-positions him as *author* (Butler, 2005). It is an image that harbours notions of both narcissism and fantasy, but to the critics it is the only ‘director’ who is ultimately answerable. One might reflect on this point in a secondary health care setting,

but my concern in translating this image to management is that in real life, re-takes do not exist; one cannot edit health care or leave the failures of care on the ‘cutting room floor’.

Secondly, as discourses of ‘truth’, flickering cinematic projections throw powerful polysemic images onto the screen, telling stories that distort space and time, re-write history, through camera angles, limitless locations, flashbacks and dreams, mirroring the non-linearity of our minds, transforming and confusing our sense of reality (Butler, 2005; Foucault, 1984a; Parker, 2002). Whilst dialectical montage skews our perceptions with visions from different angles, characters can shift between, and unnervingly undermine, the fixity of binary opposition; evil triumphs over good. As Baudrillard (2003) exclaims; the *disappearance of the real* is replaced by the *emergence of the hyperreal*, a new reality symbolically and linguistically created for us, reconstituting our self, our values, beliefs and desires (Butler, 2005; Phillips, 2003), disturbing and modifying our habitus, but ultimately it all rests on the viewer to interpret what they see.

### Chapter Summary

This introductory chapter aimed to present the reader with the structure of the thesis, the nature of the study and the proposed theoretical and methodological approach. The chapters that follow will build on a (re)conceptualisation of the secondary health care organisation through the concepts of Complex Evolving Systems (CES) (Mitleton-Kelly, 2003) and post-structural thinking (Derrida, 1976; Foucault, 1972). By employing this philosophical position the thesis critiques the dominant paradigm of management as reflected in the discourses of managerialism (Boje, 2006b) which adhere to modernist attitudes of agency, order and the underlying relations of power that this engenders and poses an alternative inter-subjective perspective that hope to radically transform management practice as the thesis moves towards its conclusions.

**Chapter Two**  
**Exploring the Discursive Landscape of Health Care -**  
*The Good, the Bad and the Ugly*



## Introducing the Hyperreality of the NHS - *The Matrix*

*“An organisation of maddening complexity”*

(Parker, 2004:189)

I start the chapter with Parker’s (2004) remark about the NHS organisation, as it proclaims an image that is startlingly apt for my secondary care context and suggests to me the frustration wrought by managerialism’s attempts to order a complex human social system through a functional, rational and scientific lens. Streatfield (2001) supports this view that organisations are inherently messy patterns of action and inter-action and do not fit the mainstream philosophical orientation of managerialism.

Streatfield’s (2001) claim cautions me against ontologically representing my context through any monotypic portrayal and that to seek out the messy patterns will inform me of order as fractal (Sanders, 1998) and context specific. The use of the term fractal, although emanating from scientific disciplines has been adopted by the Complexity community to express how evolving phenomena exhibit regular irregularity. A good example is the motion of the tides and waves on the coastline; never replicated, but exhibiting a distinct order (Sanders, 1988).

Foucault (1980: Ch2) explains that a fixed or predetermined ‘unity’ is unthinkable in a dynamic social system that is continually reconstructing itself, but recognises that, within each differentiated context or domain, several strands of historically constituted truth claims exist, forming a distinct set of legitimised knowledge that functions as a ‘discursive unity’ for that domain; core concepts, norms and assumptions around which a domain of knowledge is constructed.

Foucault (1972) considers that this legitimised knowledge, or ‘meta-image’, establish the *rules of formation*, an accepted and legitimised way of thinking about a particular (NHS) function. This order drives conforming patterns of behaviour, through agent subjectification, forming a quasi-order of ‘rules’, the messy patterns (Streatfield, 2001) that Bourdieu (1991) calls the *normative logic*

of the field. I interject early in this thesis that Bourdieu and Foucault may seem odd bedfellows, but their similarity of thinking will be elucidated as I continue.

The predominant focus of this chapter is an attempt to unravel and explore the discursive origins of this enduring knowledge that overshadows and dominates, creating a powerful discursive ‘unity’ for each local context; powerful in its ability to achieve coherence and conformity in its agents. Thus, I explore the corpus of discourse that constitute the secondary health care system, noting how each emerges from various trajectories and coalesces to construct a mosaic image for each domain. As Foucault (1972) suggests, I start with the ‘unities’ already given and from my experience in health care I recognise two distinct areas of interest where discourses and normative values do not correspond, but regardless co-exist; management and clinicians, which explains why I analogise this chapter with Sergio Leone’s epic ‘spaghetti western’; the necessary interdependency of ‘disparate agents’.

The chapter opens with an exploration of the discourses that surface from the four principal and interacting surfaces of the health care system, political, managerial, clinical and professional. Ontologically, Foucault’s thinking radically re-conceptualises the ‘social’ system at the messy, interactive micro-level, eradicating the dualist and mechanistic morphology and seeing the self as constituted by the various discourse that emerge from multifarious contexts; the *surfaces of emergence* (Foucault, 1972).

Throughout this thesis I use the term *self* as opposed to the term *identity*. The notion of *self* is an elusive concept that represents the idea of an inner core, deep inside the agent; “*a free child – spontaneous, expressive and good*”, but an entity that is overshadowed by the norms of discourse (Billington, Hockey and Strawbridge, 1998: 40). In contrast the term *identity* is more frequently attributed to a sense of who we are, but again as this thesis proceeds the complexity of both concepts is explored to challenge any notion of coherence (Billington, Hockey and Strawbridge, 1998).

My examination of each *surface of emergence* is informed by *The Archaeology of Knowledge* (Foucault 1972), a technique Foucault uses in his earlier works, *Madness and Civilisation* (Foucault, 1967) and *The Birth of the Clinic* (Foucault, 1973), to explore inter-discursivity, the way that discourses emerge from one context and become embedded and legitimised within another. Archaeology aims at a *pure description of discursive events* (Foucault, 1972: 29) and aims to expose the statements that constitute the archival image of the field. Archaeology does not seek to make judgement about the truth or coherence of the statements, but contemplates the historical emergence of a discourse and the conditions that allow statements to strategically govern a particular domain (Dreyfus and Rabinow, 1986; Kendall and Wickham, 1999).

In this respect, of particular significance is the written document, whose power is profound in the way it can define a privileged perspective of (health care) reality. Foucault (1972) contends that one must question any document, who authored it, why it was authored, what is said, what is not said and ultimately its expressive value. Foucault (1972) explains how statements have a strategic function and thus documents are never inert, but able to order knowledge and truth, by deciding what is included as relevant and valid and what is omitted, potentially reducing alternate claims or priorities to silence.

As I reflect on the literature surrounding the major fields of health care I employ Baudrillard's (Lane, 2000) postmodern metaphor, *hyperreality* to emphasise at the outset, the dilemmas of subjectivity and authenticity when attempting to represent any context. My vast experience of the secondary care field means that objectivity is impossible, but I attempt not to judge, but expose the tensions and contradictions between domains and how they entrench *différance* (Derrida, 1976). This French neologism incorporates the English *defer* and *differ* and explains how the statements and language of discourse invoke meaning through its relationship to another concept (Dumont Jr. 2008; Fletcher, 1999) constituting order through sharp distinction and reinforcing a particular 'identity' on an agent's self and their consequent practice (Fletcher, 1999). However *différance*, more significantly, can exclude or marginalise those who

do not conform to the archival image: “*A concept is recognisable for what it is not*” (Dumont Jr. 2008:62).

Derrida (1976) argues that différance promotes a hierarchy of ordinate and subordinate terms, for example work/leisure, rationality/emotion, strong/weak male/female (Sarup 1988), ordering an accustomed perspective of (clinical/non-clinical) relationships that one may recognise as I move through this chapter. A central aspect of différance is that it is inherently obstinate to influence from ‘external’ discourse as the actions and statement of agents, reinforce legitimisation by continual reference to the validity of their referent knowledge; “*the will to truth*” (Neitzsche, 1910). What is important in this thesis is the extent to which discourse from the interacting surfaces of emergence, in particular the political and managerial surfaces are able to influence and dominate the knowledge and practice within other fields.

The latter part of the chapter is a more detailed description of the study context to reflect its multi-dimensional personalities. The context’s representation of itself is just one portrayal, which may not necessarily present its true operating reality as each representation is diffracted through a particular lens. To re-balance various standpoints, I portray the study site through three lenses, the Trust’s public face, the employee perspective and my own perspective as researcher. To maintain the anonymity of the Trust I do not use any specific identifying data and only reveal that the study is centred in a secondary care NHS Trust in South Wales, UK.

### The Political Surface of Health Care Discourse - *All the Presidents Men*

*“There is nothing a government hates more than to be well-informed; for it makes the process of arriving at decisions much more complicated and difficult.”*

(Keynes, orig. 1937; 1982; 409)

Over the past twenty years Wales has experienced the emergence of a novel and challenging health care market, designed by government and driven by both

consumer demand and technological and pharmaceutical innovation. Looking at its wider context, it is notable how, since its inception in 1948, the NHS is irretrievably bound to political discourse; the NHS was a political aspiration to gain the envy of the world, funded by taxation and providing an equitable and almost unlimited service free at the point of delivery (Flynn, 1995; Harrison, Hunter and Pollitt, 1990; Newdick, 1995). The contemporary NHS continues to stand as a potent symbol of the welfare state, being the largest monopoly provider of health in the world and the third largest employer worldwide (NHS Employers, 2005); “*a unique example of the collectivist provision of health care in a market society*” (Klein, 1983: 1) boasting over sixty million customers and 1.3 million employees (Greener, 1999; Klein, 1983, Newdick, 1995; NHS Employers, 2005).

Implicit in the notion of government is the concept of governance, which Foucault (1982) conceives as the *conduct of conduct* (Dreyfus and Rabinow, 1982:220) and Dean (1999) defines as a *more or less calculated and rational activity undertaken by a multiplicity of agencies, employing a variety of techniques and forms of knowledge that seeks to shape conduct...for definite, but shifting ends* (Dean, 1999:11). This does not suggest any unjust or ominous agenda to government, but Dean (1999) asserts that one must consider what government is trying to govern, why it must be governed, how it will be governed and how will a balance between self governance and more direct forms of governance is established. Important, for this thesis, is to explore the way in which a pervasive discourse of modernist governance, defined as managerialism, is influencing agent practice in the NHS secondary care context.

### **The Evolution of British Health Care Policy - *Jewel in the Crown***

When exploring managerialism in the NHS, we cannot neglect its political history. Since its inauguration the NHS has struggled, its costs underestimated at the outset; even Bevan accepted that expectations would outstrip supply (DOH, 1997) and that the advances of medical science would outpace the public purse (NHS Information Service, 2002) and attempts to address this irredeemable dilemma has resulted in a procession of government led reforms. Blomquist (2000) states the term *reform* is exclusive to the public sector as a *taken-for-*

*granted method of solving problems; their ability to accomplish improvements is not questioned* (2000:229). Grey (2005) cynically considers that change management in organisations has become the meta-narrative, a *preoccupation* and a *fetish...a totem before which we must prostrate ourselves* (2005:90).

The dominant approach to public policy in the UK is based on mechanistic and linear thinking and the assumption that evidence gathered in one context may be transposed trouble-free to another context (Chapman, 2004). Blomquist (2000) explains that when reform fails the assumption is that failure is due to some missing link in the linearly conceived chain of rationally planned events or that implementation has been thwarted with incompetence, lack of control, co-ordination problems between differentiated units or logistic complications; dysfunctional thoughts fitting for a modernist discourse of control. What public sector reform introduces is a discourse that dictates change from ‘above’ the system, rather than from ‘within’ the system, and in the NHS, as Foucault would recognise, this allows the object of health care to be defined in line with political aspirations.

*Public Administration* (Kickert, 1997; Osborne, 2007) was the functional instrument of the welfare state, peaking in the post-war era and comprising a dichotomous split between political bureaucracy and the professions (Osborne, 2007). It represented a de-centralised and loosely controlled framework of governance administered through the Department of Health, the authoritative body, accountable for resources and the quality and quantity of service provision through the various institutions (Stacey and Griffin, 2006). At the outset a dichotomous ontology between the state and the organisation is legitimised.

Outwardly, the hospital reflected the model of the *professional bureaucracy* (Mintzberg, 1980), a model that espouses a balance between professional autonomy, self-regulation and bureaucratic control and assumed the competence of doctors, who would act in the best interest of their patients (Longley, 2007). *Public Administration* also presumed the hegemonic acceptance of its professional workforce (Osborne, 2007), but as Richman and Mercer (2004) elucidate, the NHS, with its many professions, any structural convergence to

what is depicted an apex of control did not in reality exist and it was consultants who exercised patrimonial authority over their political and relatively weak managerial colleagues (Harrison, Hunter and Pollitt, 1990; Hunter, 2002; Stacey and Griffin, 2006).

Plagued by notions of inefficiency and inadequate performance, the Cogwheel Report (1967) suggested a lack of co-ordination in medical activity, recommending that clinicians become more involved in managing the service, but little changed (NHS Information Service, 2002) until the economic depression of the 1970s catalysed a major discontinuity in political discourse, with the publication of *The Griffiths Report* (Griffiths, 1983); a discourse that significantly challenged the status and power of clinicians (Currie, 1997; Flynn, 1995).

The thrust of Griffiths' (1983) report may be epitomised by the somewhat sensationalist comment; "*if Florence Nightingale was carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge*" (Flynn, 1995:147). Griffiths recognised an *institutionalised stalemate* (Flynn, 1995:147) and hastened the notion of 'general management' into the NHS (Learmonth, 2005) and set the conditions that transformed the object of the health care through a discourse that reflected radically alternative principles.

Thus in the late eighties the NHS witnessed a managerial transition; *New Public Management*, NPM; (Hood, 1991) emerged, hailed as a marriage of two opposing principles that conjoined administrative reform and business type managerialism, constituting the concept of *public managerialism* (Kickert, 1997). Health care became redefined through a discourse that prescribed the massification of services, cost consciousness, customer choice, the saliency of management, accountability and performance management (Adcroft and Willis, 2005; Cutler and Waine, 2000; Ferlie *et al*, 1996; Flynn, 1995; Kickert, 1997; Richman and Mercer, 2004; Stacey and Griffin, 2006). Hood (1991) describes the common characteristics of NPM as a private sector style of 'professional management', whose values and norms espouse the normative control strategies

of managerialism complete with standards and performance measures, output controls and quasi-market dynamics, all set to remove bureaucratic lethargy (Harrison and Smith, 2003; Hoggett, 1996) and an assumed *institutional indifference* (Longley 2007:7).

Currie (1996; 1997) asserts any re-constitution of the manager self by the NPM focus of consumerism, however, did not necessarily manifest in reality and the façade of a NPM discourse masqueraded as a rhetorical and symbolic artefact (Flynn, 1995; Hoggett, 1996). Griffiths' (1983) rejection of the fundamental differences between the public and private sector was further critiqued by the assertion that the NHS is not concerned with profit but with wider social standards that could not be measured (Harding and Learmonth, 2004) and that the superiority of private sector models in increasing performance was mere supposition (Hood, 1991, Osbourne, 2007; Thorne, 1997). As Longley (2007) argues The World Health Organisation (1948) definition of health is; "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" a concept "*so difficult to measure that it is unfair and unrealistic to hold the NHS accountable for achieving it*" (Longley, 2007:15).

The political endorsement of NPM encouraged a move towards a more flexible and innovative service provision, where networks replace hierarchy, 'earned autonomy' replaces the 'command and control' structure and where a consumer driven market replaces a 'one size fits all' approach (Harrison and Smith, 2003). At the outset, however, Hood (1991) cautioned that the underpinning philosophy of NPM would corrode the institutions embedded in public sector 'culture' and jeopardise its honesty and neutrality, but expected that NPM would undoubtedly "*live off public service ethic capital*" (1991:16).

The expected advantage of NPM was that it would replace central government interference (Barr, 1998) but performance targets quickly countered any freedom for managers (Stacey and Griffin, 2006). Barr (1998) continues, that whilst the advantages held by a free market economy is useful in well-known circumstances, health care conforms badly to the key conditions needed for such success, explaining that the processes of diagnosis and treatment are technically



complex and unpredictable and that consumers are generally poorly informed about their condition and the various treatment options available. NPM failed to achieve its objectives and ‘professional management’ was not seen to be any more influential on NHS performance (Davies and Kirkpatrick, 1995; Harrison and Pollitt, 1994).

Kickert (1997) argued that NPM should be broadened into the concept of *Public Governance* (1997:732) contending that the restricted focus on a business-like and market orientated discourse cannot acknowledge, let alone accommodate, the socio-political environment of public sector services. Kickert (1997) contends that *Public Governance* is; “*a complex activity involving the ‘steering’ of complex networks in social policy sectors*” (1997:732) and accordingly New Labour responded with the *third way*, supported by LeGrande (2006) and informed by Giddens’s (1998) ideological compromise of left and right wing politics, attempting a harmonious balance of *social solidarity and dynamic economy* (1998:5).

The *third way* is described in *The New NHS* (DOH, 1997: Chapter 2) as; “*...neither the old centralised command and control system of the 1970s [nor] the divisive internal market of the 1990s*” but instead an approach “*based on partnership*” (DOH, 1997: 10) where a relaxation of centralised control would follow demonstrable improvement in practice (Hunter, 2000). Giddens’ (1998) model echoes New Labour’s (1997) proposals through the notion of social democracy, accommodating the principles of individualism, individual choice, partnership working, and community involvement through dialogic engagement (Falkheimer, 2007; North 2000).

In England, the *perverse incentives and distorted priorities* of the internal market are now replaced with ‘integrated care’, practice based commissioning and payment by results (DOH, 2002a; 2002b); a network- partnership approach, dubbed by Osborne (2007) as *New Public Governance* (Osbourne, 2007; Pierre and Peters, 2000; Rhodes, 1997; Smith 1999). In Wales, although the social solidarity aspect of the *third way* is adopted, through the notion of the *citizen model* (Beecham, 2006), the Government of Wales dismissal of market

economics marks a reversion to a centralised approach to health care governance. A commonality of both the Welsh and English systems is that although the objectives of both NPM and the ‘third way’ aim to reduce bureaucracy, in complete contrast a *neo-bureaucratisation* of health care is emerging where an increasing number of centralised regulatory agencies are replacing mechanisms of hierarchical control (Harrison and Smith, 2003) and eroding the notions of trust and professionalism (Longley (2007).

### **The NHS in Wales -*The Doctor and the Devils***

Politically, structural differences have always existed in the NHS in Wales. The tripartite system, abolished in the 1960s, transformed hospital administration from directly managed units to one where all services became governed by District Health Authorities and the Welsh Office (NHS Wales, 2008). As in England, this service model was superseded by the purchaser-provider split until devolution across the UK and the Government of Wales Act (Welsh Assembly Government 2006a) allowed Welsh ministers to address Welsh issues locally, resulting in a distinct trajectory for health care services (Hart, 2008).

The Welsh Assembly Government (WAG) opted to dismiss the *payment by results* (Department of Health, 2002a; 2002b) fiscal model adopted in England and advocates the *citizen model* (WAG, 2004; Beecham, 2006) as the way forward. In doing so, WAG declines the internal market, the notion of decentralisation and Foundation Trusts, and emphasises a collaborative model that builds services through robust public- provider relationships. The emphasis on the *citizen* and *public engagement* reflects Le Grand’s (2006) idea that patient should be “*Queens*” and not “*Pawns*” (Longley, 2007:11). “*Queens exercise control over their care, make choices and ensure the service works for them whereas pawns are passive recipients: done to, rather than doing*” (Longley, 2007:11).

With the investiture of a new coalition government the health care publications, in particular, *Designed for Life: Creating world class health and social care for Wales in the 21<sup>st</sup> Century* (WAG, 2005) and *A Picture of Health* (CHC *et al*, 2005) hang in the balance following the health care proposals voiced in *One*

*Wales* (WAG, 2007a). *One Wales* (WAG, 2007a) presents a new manifesto for Wales following the administrative coalition of Labour and Plaid Cymru, acting to harmonise each party's *ideological distinctions* and endorses the move away from private health care integration and the re-centralisation of the commissioning process (WAG, 2008; 2007b). Following the consultation process however the reforms proposed (Hart, 2008) seem to ignore the majority verdict for an *arms length relationship between the Minister and the NHS* (2008:1) and instead entrenches the notion of political control through the establishment of a National Board.

Running in parallel to Welsh health care policy is the review of local public services in *Beyond Boundaries* (Beecham, 2006), a response to the Welsh collaborative aspirations expressed in *Making the Connections* (WAG, 2004). Beecham similarly asserts a pluralist approach to public services that is said to place the citizens of Wales centre stage, but in discursive terms Beecham reinforces the a rational, objective and accountability based approach to managing service improvement that mirrors the (in)efficiency based claims made in health care policy. Beecham (2006) criticises the partnership approach in England and recognises the *citizen-model* as a collaborative and integrative way of integrating and transforming public services, by weakening and working beyond organisational boundaries.

### **Political Statements of Health Care in Wales - *Enter the Dragon***

In light of my earlier claim regarding the power of the written document, I now present a deconstruction of the key NHS publications since 1998 to reveal the *themes of convergence and culmination* (Foucault, 1972: 9) within their statements. I endeavour to elaborate how the micro-events, the irruptions, the breaches, the dislocations and mutations can be distorted to form a homogenous *corpus* of documents that promote cohesive claims from a political trajectory and in doing so constructs and legitimises a particular definition of health care reality that justifies the direction of political reform.

The transformation of the NHS in Wales started, pre-devolution, with the publication of a self-stated visionary document that echoed *The New NHS*

(DOH, 1997) in its desire to remove market competition, bureaucracy and the fragmentation generated by the NPM approach, mirroring Kickert's (1997) critique that; "*The internal market's emphasis on competition ran counter to the NHS's long-established philosophy of co-operation and partnership*" (NHS Wales, 1998a: Ch1). The aim of government was to return the NHS to its centralised *roots*, in the true founding spirit of Bevan; *a service available to all on the basis of need* (NHS Wales, 1998:2). One must assume that the need for this rhetorical restoration, returning the NHS to its post-war image, was fashioned from the media stories of the NHS *post-code lottery* where geographic variations in medical treatment, made more explicit by NPM would be resolved to sustain newly acquired public support (Shekelle et al, 1999).

*Putting Patients First* (NHS Wales, 1998a) clearly re-states the economic and productivity imperatives of NPM, the need to make better use of resources to provide a speedy, appropriate and effective service and its scientific allegiance is upheld by advocating the *spread of good practice* to avoid service variation. The promise of *care through performance* (1998a: Ch1) correlates the notion of effective and efficient services with strict governance and surveillance. In essence, it is a document that acts to endorse political interference in the management of the NHS in Wales by the removal of any notion of 'earned autonomy' or the freedom of managers to manage.

The publication *Better Health-Better Wales* (NHS Wales 1998b) builds on the WAG strategic vision, ruling out inequality and encouraging a healthy lifestyle with an effective, efficient, fair and responsive service achieved through accountability, performance monitoring, local flexibility, an informed public and collaborative and integrated working practices (1998b: 1.4). By stating such deficiencies the document silences any thoughts that an effective, efficient, responsive, flexible and just service already exists. In addition, it further silences the notion that integrated working and collaboration does occur in, what may already be recognised as, co-existent systems that rely on a high degree on interdependency. Even though the principles of NPM may have frustrated informal connectivity, its necessity does prevail.

The document *Improving Health in Wales* (NAW, 2001) tagged as “*Made in Wales to meet Welsh needs*” (2001:5) followed, presenting a strategic ‘blueprint’, rather than a document aimed at stimulating stakeholder participation, by setting the vision, the objectives and the measures against which reform is to be monitored and thus where ‘integrated working’ would likely be focused. I draw attention to the forward that asserts that the reforms should not be *brought about by a return to the command and control approach*” (2001:4), that their rational strategic management model underpins and the terminology employed, for example, *demand, reinforcement and accountability*, which sets a distinct ‘command and control’ trope (2001: 4, 59). The workforce are characterised as merely functional beings in what appears as a rational, mechanistic and linearly conceived method of service transformation

Further extolling the need for partnership working across the public sector, the publication, *Designed for Life: Creating world class health and social care in the 21<sup>st</sup> century* (WAG, 2005), rhetorically reconciles the disparate sectors of health and social care at the strategic level but continues to suggest that within the past five years integrated working has not advanced. The rational philosophy is evident as it describes itself as a *three part strategic framework* (2005:12) to re-design care, deliver higher standards and to ensure full engagement of staff.

The document retains the systems approach of previous publications, stating that; “*it sees communities as whole systems allowing the use of sophisticated techniques, such as flow analysis, lean thinking or statistical process control – all of them proven ways to generate improvement*” (2005: 33) and advocates the use of benchmarking techniques and the balanced scorecard approach to performance management; the addendum that these are *proven ways to generate improvement* is fierce in its ability to silence any resistance for less scientific alternatives. The question that arises is how service *improvement* is defined, but the overall premise is that the system can be linearly re-designed and objectively moved to a future state to realise its chosen vision, which requires the system agents to act with conformity and consensus (Streatfield, 2001)

Underpinning the *Designed for Life* (2005) strategy is the publication *Designed for Work* (WAG, 2006c), a strategic plan to modernise the NHS workforce in a way that again emphasises the functionality of agents who; “*must be trained to maximise their contribution, to fully utilise their skills...*” (2006c: 3). It echoes the Total Quality Management aphorism in placing; “*the right people with the right skills in the right place at the right time*” (2006c: 4). The plan assumes that the workforce and the organisational culture can be designed to engage their commitment.

The coalition of Labour and Plaid Cymru set to modify the manifesto through *One Wales* (WAG, 2007a) which acts to reassure the populace for the need for *democratic engagement...where the people of Wales will be fully engaged in any future reconfiguration of services*” (2007a: 8), but provides scant insight into how the integration of the public voice will be achieved or whether there will be any genuine shift in the balance of power. In contrast *One Wales* (2007a), whilst talking of devolved power, ratifies its own position of authority over public service reform in the statement; “*we will review the governance of public service bodies to ensure their alignment with this agenda*” (2007a: 6). The government of Wales “*strives to ensure a positive experience*” (2007a: 8) for patients and underpins this ambition with the modernist ideals of productivity, such as, a reduction in waiting times and increased accessibility, whilst attempting to restore public confidence in the delicate areas of ‘free at the point of delivery’, hospital cleanliness, nutritious food, hospital car parking charges and the access to hospital telephones.

The document states that it will; *propose a challenge for all those who have to implement the plan*, suggesting that shared values and common goals are the route to success within this rational strategic model of governance. The statement acts to control the workforce behaviour through homogeneity, consensus for political values and norms and rational authority. The productivity emphasis again is highlighted; “*the need to work harder*” is a statement which may not endear health care employees to its support, but serves to reinforce the *managerial meta-myth* (Adams and Ingersoll, 1990: 285); the implication that public services are consistently inefficient, uncommitted and wasteful. The

political conviction in the saliency of management in achieving these aspirations are clearly stated, borne out by their desire to; “*strengthen NHS finance and management*” (WAG, 2007: 8-9). Any notion of freedom from political surveillance is opposed by the statement that; “*It is essential that the First Minister and Deputy First Minister are kept fully and promptly informed across the range of government business*” (2007: 12)

Returning to the integration of the public voice, health care reform is legitimised from an alternative trajectory, as non-political approval for *Designed for Life* (2005) is found in the joint publication, *A Picture of Health: How the NHS could look in 2015* (CHC et al, 2005). The authors state they; “*represent the patients, professionals...and academic institutions*” locating themselves unreservedly as authorities who represent the citizens of Wales. The authors imply that they stand in judgement of the government’s proposals, but their response justifies and thus ratifies the political claims of *Designed for Life* (2005), locking together discourses from several fields in a unified voice.

The marketing strategy employed by this document is noticeably different to the somewhat plain policy documents, perhaps set to appeal to the populace, as the photograph on the cover makes a transparent plea for change, a handsome child, blonde, about two years old with a hand outstretched, as if in need of attention. Turn the page and we see an elderly gentleman with hands clasped in an anxious pose and the leading paragraph; “*What could the NHS and the wider health system look like in 2015? There are many changes already underway, but what kind of service are they leading us towards. And what will it mean for patients? This document is an attempt to answer these questions...*” (2005:1). The answers, I presume attempt to dissipate this gentleman’s profound concern for a health service that is supposedly failing its nation.

Aiming to legitimise the strategic direction of reform, this document paradoxically provides several examples suggestive of spontaneous emergent change, the irruptions and micro-level events that Foucault suggests are marginalized as isolated innovation. It is simple; if there is no documentary evidence of before and after measures, no proof of collaboration, of partnership,

then it is disqualified as *naïve knowledge*, that Foucault calls *savoir de gens*, local experiential knowledge that is located further down in the scientific hierarchy (Foucault 1976: 82) and in the NHS the lack of documented evidence of changing processes allows for the political assumption that service adaptation is not occurring spontaneously.

At this moment, it is apposite to re-visit the significance of Parker's (2002) euphemism, at the start of this chapter, as health care reform is presented with an objective and rational approach to service delivery that attempts to remove, rather than accept, the *maddening complexity* and the messiness of interactive order (Streatfield, 2001); a reductionist exercise that attempts to transform the more visible aspects of health care service delivery into a simplistic and linear process.

### **A Quality Framework of Governance - *Dead Ringers***

Since its inauguration in 1948, 'quality' in the NHS had been thought of an inherent dimension of the professional 'work ethic' (Donaldson and Gray, 1998), but an increasing number of concerns with the regulation of clinical expertise and a heightened public awareness of failures of care in the late nineties (Baker, 2000; Davies, Mannion and Marshall, 2001; Whitfield, 2000) led to a new regulatory discourse for clinical practice; clinical governance. When exploring the discourses of managerialism it may be a discourse that could easily be overlooked as immaterial, but the origins of clinical governance discourse are *unmistakably political* (Sweeney and Cassidy, 2002: 124) and statements appear to reorder the notions of self-governance and autonomy.

The governance of clinical practice is not a novel concept, but the integration of managers into the clinical teams led to them having a greater degree of accountability for the quality of the service they provided (Baker, 2000). Potentially this integration of corporate accountability may have ultimately generated the clinical governance framework; "*a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care...*" (Department of Health, 1998, 3: 2). In a similar manner the systems approach advocated assumes that



managers are able to plan and construct predictable clinical outcomes in a rational and linear manner (Sweeney and Cassidy, 2002).

Published at a timely moment, when a group of distinguished doctors had been struck of for failing to follow political guidelines the document, *A First Class Service: Quality in the New NHS* (DOH, 1998) implied that lapses in quality, a term that seems defined in relation to a ‘failure of care’ (Davies, Mannion and Marshall, 2001), were due to the breakdown of professional self-regulation, the absence of national standards and the lack of clear incentives and levers for improving performance (Baker, 2000; Department of Health 2000). The objectives of clinical governance are just, genuinely hoping to stimulate a more open, reflective and candid environment (Nicholls *et al*, 2000), but by re-defining quality, Loughlin (2004) considers that government rhetoric skewed reality by alluding to “*a pre-quality dark age when no-one was in charge*” (2004:27), where quality was deemed a *peripheral concern* by NHS workforce and had to be re-discovered (2004: 27).

Thus, framed as a moral and ethical discourse the *quality revolution* (Loughlin, 2004) initiated the streamlining of processes to eliminate variations in care and gave politicians the power to modify the terms of professional regulation, through the processes of *evidence-based medicine* (Evidenced-Based Medicine Working Group, 1992), national service frameworks, clinical audit, benchmarking and clinical risk assessment (Baker, 2000; Donaldson, 2000; Sheckelle *et al*, 1999; Swage, 2000). Service variation was seemingly re-attributed from the failings of NPM to a clinical discourse and to the lack of professional regulation and hence the former *heroes* of the NHS, the clinicians, were transformed into its *villains* (Davies, Mannion and Marshall, 2001).

Clinical governance discourse defines *quality* as; “*doing the right things, at the right time, for the right people and doing them right first time*” (DOH, 1998) that again echoes the TQM mantra (Flynn, 2002). Baker (2000) contends that clinical governance asserts that the NHS; “*no longer tolerate[s] failure, but celebrate[s] success*”, suggesting that universal success in medicine can be guaranteed; an assertion that could never be fulfilled in reality (Baker,

2000:140). Flynn (2002) further argues that the discourse of clinical governance makes assumptions that are value laden and contestable, for example, to whose standards do they relate to and that methodologically their procedures are unsound in their ability to measure less tangible data.

Benchmarking, the core and mandatory evaluation tool introduced from the private sector, is the cornerstone of quality performance management (Department of Health 2002b) by proposing a collaborative-competitive approach to quality improvement by judging one organisation against another. However it is criticised for not being able to accommodate the softer and intangible aspects of services, such as patient satisfaction and its success in reality has not been demonstrated (Fowler and Campbell, 2001; Guven-Usly, 2005; Harrison and Lim, 2003; Jones, 2001; 2002; Norcott and Llewellyn, 2005; Wait and Nolte, 2005; Webster, 2002, Wolfram-Cox, Mann and Samson, 1997).

Whereas the productivity focus of managers created dissent between clinicians and managers (Hunter, 2002) clinical governance is well accepted by health-care professionals, believing it is a sincere move by the government to redress quality (Hurst, 2003). Hackett (1999) however concludes that doctors portray two opposing paradigms, recognising the importance of clinical freedom and judgement, but simultaneously understanding the need to scrutinise their performance to minimise unacceptable variation.

The contemporary notion of *professionalism* in health care is of interest as it rewrites the established “do no harm” ethos around a managerialist ‘ethic’ where professionals are expected to reflect on their own behaviour and harmonise professional, patient and additionally ‘organisational’ interests (Wear and Aultman, 2006) thus modifying their practice towards non-clinical priorities that reflect managerial imperatives. Friedson (1994) asserts that the former keystones of medical ‘professionalism’ are being replaced with a hierarchical and elitist form of surveillance and Huntingdon, Gillam and Rosen (2000) warns; “*if clinical governance is driven by an agenda of control and risk management, the result will be compliance and not commitment*” (2000: 680).

Regardless of the bounds of 'professionalism', the regulation of all health professionals is set to change (DOH, 2006; 2007a; 2007b). The General Medical Council (GMC) has regulated doctors' activities, since 1858, but has recently come under criticism due to several high profile incidents in the 1990s (Whitfield, 2000). Adding to this is a change in the control of the two most central elements of medicine, the medical register and medical education, which are being placed in the hands of committees over which the medical profession will have less influence. Godlee (2006a; 2006b) suggests that this reform strikes right at the heart of medical professionalism, which Sutherland and Dawson (1998) believes shifts the balance of power, legitimacy and autonomy away from clinicians, further diminishing medicine's meritocratic identity, their intellectual freedom and their ability to pursue medical knowledge in a critical and rigorous manner.

### Discourses Surfacing from a Managerial Field - *How the West was Won*

*"The inherent preferences of organisations are clarity, certainty and perfection. The inherent nature of human relationships involves ambiguity, uncertainty and imperfection. How one honours, balances and integrates the needs of both is the real trick of management"*

(Pascale and Athos, 1982:105).

Whilst I do not seek to construct a genealogical genesis of the evolution of management discourse a major discontinuity in management practice emerged during the epoch of modernism that transformed the 'relations of production'. This change was catalysed by the rise of Western industrialisation in the eighteenth century; concurrent advances in the scientific disciplines and the metamorphosis of what has been dubbed the modern capitalist society (Costea, Crump, and Amridis. 2008; Pollard, 1965). Driven by the Enlightenment dream, the modernist discourse of science was believed the panacea to emancipate human potential in a bid to progress society as a whole (Bilton *et al*, 2002).

Managerialism, in its most simple terms is the application of management techniques and is an evolving concept. However, dominant in its discourse is an

intricate and multi-faceted framework of contradictory discourses and particular techniques that orientated around the notion of rationality, an allegiance to scientific knowledge, techniques of surveillance and accountability and concepts that appeal specifically and ingeniously to the 'human attributes' of agents (Costea, Crump and Amiridis, 2008; Grey, 2005). Managers consequently became lauded and legitimated as a beneficial dimension of the organisation (Rowlinson, Toms and Wilson, 2007); the *ethical agents of emancipatory change* (Harding and Learmonth, 2004:188), but as Grey (2005) reflects managerialism is interested in getting the job done as quickly as possible rather than focusing on the socio-political agenda.

### **Exploring Managerialism in the NHS - *El Dorado***

Throughout its evolution the management of the NHS has always been perceived as problematic (Harrison, Hunter and Pollitt, 1990; Joyce, 1999) and the Griffiths Report (1983) placed NHS management at the top of the agenda triggering a profound change in the evolution of NHS management discourse. The managerial reform espoused in *Working for Patients* (DOH, 1989) appeared to support a *post-bureaucratic* (Grey, 2005) doctrine of leaner, flatter and more flexible systems and in an area like acute health care, with its less than predictable outcomes, this organic ontology seemed appealing. However, running counter-intuitive to this philosophy, NPM (Hood, 1991) introduced private sector techniques, such as quality management, measures of customer satisfaction, quasi-market economics, cost control (Adcroft and Willis, 2005; Cutler and Waine, 2000; Ferlie *et al*, 1996; Kickert, 1997; Stacey and Griffin, 2006) together with the functional rationality of traditional strategic management (Adcroft and Willis, 2005), a scientific 'tool' to help managers, plan, lead and control performance (Streatfield 2001).

Politically it had been recognised that the occupational 'elites', especially the medical profession, obstructed policy change by avoiding debate and local resistance; since its founding the NHS policy decisions had been a complicated bargain between several stakeholder groups most notably government, bringing to bear money and power to doctors (Harrison, Hunter and Pollitt, 2003; Hunter 2002; Klein, 1995). Although the notion of consensus means that no one actor

can institute change, its weakness is that it only takes one party to veto it and it was the medical profession that was deemed to wield enormous influence; NPM transformed this relationship (Harrison and Pollitt, 1994; Kowalczyk, 2002). The government acting as the guardian of NHS services had preferred it was they that chose to define what services to deliver, even if they did decline to acknowledge any responsibility for the consequences wrought (Baker, 2000; Young, 2000).

Government policy spoke of a greater freedom for hospital managers (Cutler and Waine, 2000; Pollitt, 2003), but the strict focus on competition and performance indicators shifted the management focus away from social concerns to outputs and costs (Davies and Lampel, 1998). Political statements had redefined the 'object' of health care in terms of (in)efficiency and consequently NHS management became politicised and distorted the values managers might have wished to uphold (Carney, 2006; Hunter, 2002) by attempting to remove the socio-political context from the health care equation (Carney, 2006; Cutler and Waine, 2000; Pollit, 2003). Even though it is recognised that managers values to do not always reflect the performative agenda, what emerged as a consequence of this major discontinuity in the landscape of health was the start of an adversarial and fractured relationship between managers and professionals and a failure to achieve fiscal objectives (Hunter, 2002; Pollitt, 2003; Sutherland and Dawson, 1998; Young, 2000) stimulating a vicious cycle of initiatives to improve performance through explicit standards and measures, regulation, accreditation and external review (Seddon 2005; Pollitt 2003, Harrison and Lim 2003; Thorne, 1997; Walshe 2003).

The outcome is a rigorous discourse of performance management (Davies and Lampel, 1998) that promotes the belief that *what gets measured gets done* (Baker, 2003:43) even though data without context is meaningless (Adcroft and Willis, 2005). A paradox emerged where managers striving for 'earned autonomy' and not wishing to be held accountable generated a risk-averse and procedure-bound approach that countered any local organicity, flexibility and creativity (Hunter, 2000; Pollitt, 2003).

New Labour modified what they dubbed the *perverse incentives* of NPM and introduced a mix of quality indicators and clinical audit (DOH, 2002b) and the WAG followed suit, but, in the NHS, measurable elements are rarely independent and focusing resources in one area would result in other areas, especially those not being measured, failing (Adcroft and Willis, 2005).

An article by Davies and Lampel (1998) provides ample critique of performance indicators suggesting that the evidence they provide is weak and that interpretation of such feeble data becomes the major pitfall of performance management. The authors argue that rather than facilitating improvements, the *tightening the screw* (1998: 160) philosophy of performance management has generated adversarial and defensive behaviour that is detrimental to service development. Of further concern is whether meeting a target encourages an organisation to stabilise, service transformation consequently grinds to a halt as the political aim has been met, to grab the headlines with good news (Adcroft and Willis, 2005). Of interest is that it appears Trusts are now labelled as poorly performing regardless of their performance, but because they have not collected key performance data (Healthcare Commission, 2008).

Evidence does exist that in England and Wales there have been pockets of improvement although this mainly points to increases in efficiency and accessibility (Longley, 2007) but Pollitt (2000) argues that real increases in organisational effectiveness have been hard to demonstrate and the full cost of reform may be obscure, especially in terms of costs to clinical outcomes, the elderly and mental health, areas that are not so rigorously measured.

### **The ‘Opposition’ of Efficiency and Effectiveness - *Keep on Running***

I apologise for falling in to the trap of binary opposition, but the academic literature on managerialism compels me to consider the symptoms of these two delineated concepts even though I appreciate that any universal definition is unclear. In the most basic form efficiency relates to the optimal use of inputs and resources whereas effectiveness relates to outcomes and the achievement of a specific objective (Mullins, 1999), assuming that the objective is unambiguous.

The stereotypical image of the public sector organisation is one that is less efficient than its private sector counterparts (Pollitt, 2003; Ranson and Stewart, 1994) but Pollitt (2003) argues in the public sector the concept of success is difficult to measure, especially as there is no notion of profit. The fundamental difference between the two sectors is that private sector is concerned with efficiency where the NHS is concerned with efficacy; potentially a clash of two opposing discourses. In the NHS, the establishment of the 'internal market' steered the focus towards efficiency using input-output ratios to reduce the unit costs of treatment (Adcroft and Willis, 2005; Kickert, 1997; Newdick, 1995) but by translating private sector values and techniques the government made a huge assumption that these could and should be transferred, especially in their disregard of public sector operations as a 'context-dependent craft' where one size definitely 'does not fit all' (Hagen and Liddle, 2007; Haynes, 2003; Hewison and Griffiths, 2004; Pollitt, 2003).

Simon (2000) furthers that this lack of fit has resulted in continuing government control and may explain the move towards centralisation in Wales, to "*enforce the rules of the game*" especially in relation to provision of non-elective services that would be less viable for the private sector. The emerging question surrounds the political definition of the terms efficient and effective and in which way do the intangible 'measures' of politicians demonstrate improvement. Welsh policy documents (WAG, 2005) define the effectiveness of performance in terms of reduced waiting times, the meeting of specific outcomes, and increased patient choice, but the rising expectation of what can be achieved within fiscal constraints, leaves health care with a huge mission that reflects the heroic aspirations of politicians (Fitzpatrick, 2001).

The political preoccupation with performance management is grounded in the claim that performance management correlates with improved 'effectiveness' and tangible benefits (Adcroft and Willis, 2005; Bridges, Dor and Grossman, 2005), but the notion that clinical effectiveness could be transformed into tangible and objective measures remains vigorously resisted (Pollit, 2003, Simon, 2000, Ranson and Stewart, 1994). Some are of the opinion that targets

are divisive rhetorical devices to win political kudos rather than any genuine concern for public interests (Adcroft and Willis, 2005; Boden, Cox and Nedeva, 2005; Pollitt, 2003).

The NHS does not exist in a vacuum and it is essential to understand its operation as a complex mix of visible and invisible and tangible and intangible elements, rarely independent and frequently non-linear in their impact and thus the poverty of the reductionist approach of performance management is how it simply yields meaningless data that lacks any contextual sense (Adcroft and Willis, 2005; Cutler and Waine, 2000; Greenwood, Pyper and Wilson, 2002; MacFarlane, 1994). Adcroft and Willis (2005) creatively compare performance management to the analysis of a piece of music by listening to the notes of one instrument.

### **Managerialism as a Rational Discourse – *The Ladykillers***

NPM heralded the classical rational strategic techniques of the commercial sector into the public sector through strategic planning, re-engineering, customer service, quality assurance and explicit measures of performance management (Dixon, Kouzmin and Korac-Kakabadse, 1998; Hood, 1991; Hoskin, 1998; Joyce, 1999). As we recognise, in Wales, these elements of management are now ingrained into health care policy through the ‘validating’ statements of political discourse. Managerialism supports the practice of determining a clearly defined vision at the strategic level, decisions on how objectives will be met at policy level and at the tactical level how these plans will be implemented and evaluated through tangible and measurable outcomes (Adcroft and Willis, 2005). The statements of managerialism reinforce the strategically dominant position of managers as the prime benefactors of economic and political power, engendering the division of labour and the need for corporate strategy to fill the space caused by such workplace differentiation (Clegg and Dunkerly, 1980; Flynn, 1999; Knight and Morgan, 1991; Parker, 2002; Reed, 1989). It is a discourse that engenders hierarchy and dichotomy through assumptions of managerial objectivity and the essential function of management to control the destiny of an organisation in a predictable manner (Streatfield, 2001).



The underpinning framework of rationalism reflects Weberian thinking, where the workforce submits to managerial decision-making and power through *rational-legal authority* (Grey, 2005) and thus dualism and difference is engendered with the potentiality for marginalisation. However, Vickers and Kouzmin (2001) believe managers are oblivious to the *pain* they may inflict on others in the name of organisational efficiency. Rationality is a form of thinking that strives to be clear, scientific, systematic and explicit about how things ought to be (Dandeker, 1990; Dean, 1999) and presupposes that managers can remain psychologically and emotionally objective, separate from the organisation, allowing them to be more demanding of their workforce (Joyce, 1999). What is ironic for the NHS is not only the bureaucracy that this (re)generates, but how conformance reduces an agent's discretion and choice and ultimately removes their ability to think and respond, countering the government's intent to stimulate innovation and change (Hunter, 2000). The organisation is de-humanised, devoid of passion, prejudice, personality and agency (Grey, 2005).

Grey (1996) highlights that the dominance of a rational body of knowledge in managerialism marginalises approaches that do not necessarily conform with the technocratic approach to management and this subjugation and suppression leads me to endorse Boje's (2006b) definition of managerialism, as I consider it apposite for this critical and post-structural account; "*the manager's view that comes to dominate the polyphony of voices, as the only legitimate voice, as the agent's voice who controls on behalf of the owners or shareholders*" (2006b:1). The appeal of this definition is that it reflects a dynamic in the public sector that managers are expected to adopt and embed the norms of others and these norms are not necessarily their own making.

### **Managerialism as a Scientific Discourse- 9 to 5**

The rise of industrialisation in the late eighteenth century judged the naturally innovative and liberalist character of humans a threat to the modernist claims for certainty and predictability and to the capitalist desire for efficiency and hence management discourse adopted the canon of scientific management in a gallant attempt to ensure this rationale (Craib, 1992; Dandeker, 1990; Parker, 2002; Pollard, 1965). The faith in deductive logic and positivist science as the means

to uncover universal laws and absolute truths consequently subordinated agent experience and intuition as lower down in the scientific hierarchy (Foucault, 1980; Sanders, 1998; Sarup, 1988). In the NHS this has manifest in the concept of evidence-based medicine, a concept that complies with the paradigmatic dominance of science and where evidence from clinical research is promoted over expert opinion, intuition and unsystematic experience (Evidence-Based Medicine Working Group, 1992).

In alignment with the rational and scientific body of knowledge the principles of scientific management, espoused by F.W. Taylor, emerged to control agent behaviour and fix outcomes, conceiving human systems as closed systems, functioning in a purely mechanistic manner and agents as merely instrumental to this process; the machine-based model and metaphor is clearly apparent in traditional management discourse (Chapman, 2004; Grey, 2005). Predictable and deterministic systems of course do exist in the physical world, but in any social systems, determinism is neglectful of the complexities of human agency and 'Taylorism' emerged well aware of the complexities of human agency and patronage and sought to redistribute agent power by removing autonomy, scientising work place activity and the division of labour; the machine became the model and the metaphor (Grey, 2005). Eller (1994) explains that without robust disciplining and surveillance mechanisms, it was considered that thoughts would turn to self-interest generating the suspicion of inefficiency and waste; scientific management was deemed the way forward to curb such inadequacies.

Pollitt (2003) considers that neo-Taylorisation of public sector managerialism diminishes the 'patronage' of the professional disciplines, especially in medicine. This may reflect the problematic of engaging clinicians, in the secondary care context, with TQM and lean management approaches where the recalcitrance of consultants is blamed on the *failure to progress* and suggests that change processes must stay sensitive to the nature of medical work and include the vital element of clinician negotiation (Blumenthal and Scheck, 1995; Ham, Kipping and McLeod, 2003; Joss and Kogan, 1995; McNulty and Ferlie, 2002).

In essence the central focus of scientific management is *Performativity*, defined by Lyotard (1984) as “*the optimisation of the relationship between input and output*” (1984:11) where the pragmatics of rationality and science is judged as the only logical direction and “*demands clear minds and cold wills*” (1984: 62). This former statement may clarify why scientific management is not accepted by clinicians who do not necessarily consider medical treatment as a linear and systematic. However, one may consider that the systematisation and devolution of tasks to less qualified roles, now pervasive in the NHS, certainly lends itself to organisational rather than ‘consultant’ control.

The problematic of scientific management is that it cannot accommodate the indeterminacy of public sector organisations where boundaries are permeable and relationships are crucial to its operations (Haynes, 2003). The futility of achieving control through scientific methodology is thus recognised by the voluminous academic texts dedicated to such failure, but in managerialism the Taylorist (1913) notion prevails; “*the fundamental principles of scientific management are applicable to all kinds of human behaviour*” (1913:7) continually valorising the ‘abilities’ of managers (Grey 1996), under the “*seldom tested declaration that that the application of more and superior management would provide an effective solution for a wide range of economic and social ills*” (Pollitt, 2003).

What is regrettable is that the colonisation of managerialism by scientific and rational discourse seems to detract from Owen’s original pluralist ideals on managerialism in 1813. Dubbed the forefather of managerialism, Owen believed in applying a context-specific collective and egalitarian approach to management to emphasise its interdependency with public interests (Pollitt 2003). Unfortunately the dominant statements of managerialism have evolved to create a discourse that correlates efficiency with managerial ability, authority and accountability.

### **The Notion of Agent Commitment – *The Three Musketeers***

Countering the raw functional and purposeful techniques of scientific management, a more subtle manifestation of managerialism is recognised in

discourses that attempt to govern the ‘functional self’ through socio-political discourses that appeal to commitment, shared organisational values or ‘identity’ and self-actualisation (Costea, Crump and Amiridis, 2008). This discourse acknowledges the messy, fluid and ambiguous nature of agents (Grey, 2005) and the focus moves from managing outputs to the softer relational aspects of managing people by removing conflict, bureaucracy and supervision, which hypothetically would dissipate difference, even if only at a superficial level. The discourse appeals to the ‘human relation’ theories of Maslow (1987, orig 1943), Herzberg (1968) and McGregor (1987), where agents are recognised as having social, relational and self-satisfying needs, that Taylorism attempts to eradicate, but that human relation theory attempts to shape even though the underlying principles of performativity and control remains central (Grey, 2005).

The illusion is that agents can be ‘empowered’ by constructing a homogenous and cohesive organisational ‘identity’ or ‘culture’ and shared values and its motives are borne out by commitment-oriented business models that embody terms such as, the *Art of Japanese Management* (Pascale and Athos, 1982), *Organisation Man* (Whyte, 1961), *Organisational Culture* (Deale and Kennedy, 1982; Peters and Waterman, 1982), *The Learning Organisation* (Senge, 1990) and the *citizen company* (Handy, 1998). Discourses also allude to the notions of *emotional intelligence* (Goleman, 1996) and *stewardship* (Block, 1996) and transformed the concept of management into models of leadership, such as *transformational leadership* (Bass and Alvolio, 1993). I do not propose an in-depth study of leadership as this is not the main focus of my thesis, but suggest that the notion of leadership could be conceived as a management tool to control agency, through influence and intellectual stimulation (Bass and Alvolio, 1993) rather than through rule-based and disciplinary processes.

This discourse is recognised in the public sector (McGillivray, 2005) and the NHS secondary care sector (Akella, 2003; Worthington, 2004), although research argues that the creation of a homogenous culture creates tension between what is deemed professional and organisational values (Kirpal, 2004; Worthington, 2004). Paradoxically, research suggests that the promotion of a NHS identity that reflects operational difficulties, increasing staff turnover and

budgetary constraints actually impacts negatively on workforce commitment (Arnold *et al*, 2003; Kirpal, 2004).

Kurtz and Snowden (2008) explain that it is thought that if an organisation cannot manage a cohesive organisational identity then the silo and a silo mentality, blamed for many organisational ills will emerge. However, the authors argue that silos operate as well functioning and context focused ‘teams’ who display the advantages of rapid communication, shared language and contextual understanding and the adaptive ability to generate a cohesive and consistent response to demands.

The notion that organisational culture can be engineered is critiqued by Schein (1984) who defines organisational culture as; “*a pattern of basic assumptions that a given group has invented, discovered or developed in learning to cope with it’s problems...and have worked well enough to be considered valid and to be taught to new members as the correct way to perceive, think and feel...*” (1984:3). Schein (1984) represents ‘culture’ as an emergent phenomenon, evolving and legitimised over time rather than ‘being’ characteristics that can be imprinted on agents.

As a management tool, this discourse offers a credible argument, acting at a deeper emotional level of self and considers that action based on human commitment transcends rule-following behaviour improving loyalty, motivation, morale and thus organisational performance (Cohen, 1993; Whetton and Godfrey, 1998). ‘Commitment’ as a major *discursive currency* is constituted by the belief that “*an organisation’s culture is the key to competitive advantage*” and where; “*strong cultures [are] conceived as the solution for increased quality and productivity...*” (Costea, Crump and Amiridis, 2008:667) and reflects Gramsci’s unease that discourse can engineer and cultivate a new human type to fit capitalist needs, *capitalist man* (Joll, 1977).

Consequently agents are exposed to the ‘organisational values’ expressed through mission statements, human resource policies, company slogans and uniforms to inspire an agent to work towards organisational goals (Grey, 2005:

70; Parker, 2004). As Grey (2005) declares the ideation of such discourses are founded on the belief that success ensues “*if you could just get the culture right. Unfortunately it proved to be a big if*” (2005:66).

### Discourses Surfacing from the Field of Nursing - *Carry on Matron*

“...consumerism cracked the vessel of nurse knows best”

(Wright, 2004: 15)

Nurses make up the largest part of the clinical workforce in healthcare and presently, in the UK, there are almost 400,000 registered nurses (Royal College of Nurses, 2005a). In some respects their role is incomparable to a hundred years ago, and yet in many ways it remains the same. The concept of nursing is multi-faceted (Henderson, 2006) and is transforming as new discourses co-evolve with the established, shifting the legitimised norms, integrating the discourse of caring with discourses that generate new expectations. The discourse of managerialism, in particular, is adapting the landscape of nursing (Bradshaw, 1995; Wright, 2004) ditching the ‘*old order with its staid certainties ...*’ (Wright, 2004:15)

A review of the academic nursing literature denotes a concern for the transformation of the norms of caring and this section explores the impact of modernism on this core function. The ‘nursing’ literature also depicts a growing interest in the discipline of organisational management and behaviour, especially from countries such as, Australia, The United States, Canada and the United Kingdom; countries that have been seen to adopt a modernist approach to health care. It is possibly reflective of their numbers, rather than their militancy, that nurses have taken the lead on such research, as little is to be found in the academic journals of any other health care profession.

### **A Historically Constituted Discourse - *The Lady with the Lamp***

Where better to start an exploration of the discourses that criss-cross the profession of nursing than with the symbolic potency of Florence Nightingale (1820-1910) ‘christened’ *The Lady with the Lamp*, following her ambitious struggle to improve the plight of soldiers in the Crimean war; a mythical

portrayal that often imparts an image of a romantic, retiring, gentlewoman; *sticky-sweet, submissive and self-sacrificing* (Salvage, 2001:172) and whose status is retained in contemporary nursing (Pulliam 2002; Salvage, 2001). Libster (2001) considers Nightingale as the “*fiery mother of a holistic, caring profession*” (2001: v), but suggests that some images of nursing silence the politically intense aspects of Nightingale’s legacy. So why does the myth persist? Salvage (2001) suggests that there are many who want this image to continue, senior nurses, physicians and managers supposedly; “*to keep nurses in their place*” (2001: 172).

The academic literature maintains that nursing has a prismatic image, veering from matriarch to whore, ministering angel to battleaxe, domestic worker to the contemporary autonomous professional (Chiarella, 2002; Henderson, 2006; MacDonald 1995; Salvage, 2006; Fletcher, 2006, 2007; Waters, 2008). Whilst some (Fletcher, 2007) consider nurses are stereotyped, others jest that all descriptions contain a ‘grain of truth’ (Salvage 2006). The public perception of nursing is similarly difficult to judge (Fletcher. 2006), but is likely affected by media depictions of the barking matron, soap operas that simulate the seamy, and steamy side of hospital life and documentaries exposing nursing malpractice (Salvage, 2006; Traynor, 2004).

### **The Notion of Caring - *Misery***

Historically, the role of the nurse is associated with the *act of caring* (Libster, 2001), but *care* is an imprecise concept to grasp, even more confounding when conjoined with the equally vacuous concept of health; health is a meaningless term awarded to a metaphysical concept, although one that is given presence through its embodiment in every agent in Western society (Parker, 2004). There are many characterizations of the word *care*; March (1925) provides a historical context that suggests the synonym *watchfulness*, appropriate for my nursing context, but nursing care exceeds the notion of pastoral or emotional support and I adopt these two more contemporary definitions thus; “*to provide physical needs, help or comfort*” and “*protective and supervisory control*” (Collins, 2004: 256) providing a description that signifies the traditional aspects of the nursing role that seem less cherished in today’s workplace. Libster (2001)

considers that the art of caring is now being blended with the scientific techniques of bio-medical science, but Bradshaw (1995) believes that nursing should challenge the underpinning ethic of this transformation.

With each decade nurses have become better educated, better paid and more autonomous (Salvage, 2006) and the role is beginning to shift away from a merely a caring role (Libster, 2001; Watson, 2006). The delegation of tasks to unqualified nurses, the emergence of nurse-led units, the ability to independently prescribe and new roles and titles that reflect greater autonomy erode the vision of the nurse as the doctors' 'handmaid'. Nurses now act as autonomous practitioners or as ward managers, adopting the role of a business manager (Bradshaw, 1995). Hay (1994) argues that this is the "*pseudo-professionalisation of nursing complete with pseudo-managerial gibberish*" (1995: 43) and allows them to "*identify with the aggressor*" (Gordon, 1991: 222) However Doherty's research (forthcoming) concludes that the requirement of nurses to focus on quantitative targets is disempowering any autonomy to practice.

Nevertheless, morale in the profession is low and new roles aimed to boost self-esteem, have not been translated into job satisfaction, arguing that the managerial regime is removing the challenge and distorting standards (Corbin, 2008; Hehir et al, 2006, Madge, 2006; Salvage, 2006; Watson, 2006). Job satisfaction in nursing is correlated with the ability deliver patient care in line with 'standards', autonomy and sound clinical relationships (Blythe, Bauman and Giovanetti, 2001; Cavanagh and Coffin, 1992; McNeese-Smith, 1995; Wheeler, 1998). Smy (2005) argues that new roles have emerged at the detriment to their role as carers, a role that has been the central tenet of nursing for decades and claims that nurses do not identify with bed making and washing patients anymore. Smy (2005) explains that; "*You can't put a price on caring, and because of that it has become less valued*" (2005: 17) an opinion that is well supported in the academic literature (Kalisch and Kalisch, 1987; Savage, 2006; Strasen, 1992; Wood, 2000).



It appears that the notion of caring fits with what Foucault (1980) describes as *ordinary* as opposed to *valuable* and as Derrida (1976) would argue, the boundaries of such binary distinction should be critically challenged. As Foucault (1972) argues it depends on how an object is defined as to how events and statements revolve around the object. The Western world has come to perceive caring as ‘dirty work’ as dominant social definitions constrain the value of the caring role (Salvage, 2006). I wonder if the discourses of science is attempting to increase the perceived ‘value’ of caring and diminish the binary opposition.

The Royal College of Nursing (RCN) Conference (2005b) *Too Posh to Wash* highlighted how the caring norm of nursing is waning and asserted that caring must remain an essential component of the nursing role. As the gatekeeper’s of their professional ‘identity’, it seems that the RCN are keen to re-establish the caring and compassionate image, and perhaps the Nightingalesque illusion. However, Falk- Raphael (1996) argues that a new construct of caring is evolving, *ordered caring*, suggesting an oppositional concept that reflects increased systematisation, regulation. Falk-Raphael (1996) argues that a modernist, patriarchal and capitalist discourse is transforming the paradigm of contemporary nursing, re-designing caring in a way that subjugates its ‘feminine’, intuitive and ethical aspects.

The existence of a document entitled the *Fundamentals of Care: Guidance for Health and Social Care Staff: Improving the quality of the fundamentals aspects of health and social care for adults* (WAG, 2003) is perhaps evidence of this new orientation. One might wonder at whom the document is targeted, with its cheery cartoon-like cover of smiling faces. The pictures depict, in bright colours, a politically correct representation of society for whom this document aims to protect and I sense a rather explicit and patronising approach to the health and social care professionals that are expected to engage with this document. The document seems to minimise the less than pleasant reality of care and the emotional and distress that both carer and client may frequently experience. However, in a modernist tenor, the document states twelve practice indicators that service users are entitled to expect, ruling out any notion of

inequality or inconsistency in care; the idea that care is an intuitive and individualist concept is denied through its omission.

If as Kitson (1999) contends that the essence of good nursing is “*the ability to care for a patient as a whole person*” (1999: 42) then the standardisation of processes and the task led focus of their new scientific episteme is surely counter-intuitive to this fundamental need. One might consider that the discourse of science is challenging this perspective, modifying the traditional ethic of caring in the utilitarian corporate world of health care, seemingly moving away from its altruistic and self-effacing image to encompass a scientific episteme and the rhetoric of autonomy and empowerment (Bradshaw, 1995; Harrison, 2006; Watson, 2006). This rational turn is further supported by evidence that concludes that the emotionality of nursing is undervalued by a rational discourse, suppressed as an invisible skill (Bolton, 2002, Bone, 2002, Brown and Brooks, 2002; Mark, 2005; Mumby and Putnam, 1992). Fletcher (1999) contends that ‘softer’ competencies tend to *get disappeared* (1999:6) not because they are ineffective, but because they are ‘out of step’ with the deeply entrenched modernist discourse about what constitutes good workers and successful organisations. Watson (2006) claims that caring is fast becoming “*a technical- industrial quantitatively time bound production line*” (2006:257)

### **Exploring the Subordination of Nursing -*The Stepford Wives***

Regardless of their new academic qualifications, autonomy and managerial roles, it is suggested that the voice of nursing continues to be marginalized. This perceived subjugation emanates in part from the perception of caring as *dirty work* (Salvage, 2006: 259) and the notion that the nursing role orients around a female and ‘feminine’ discourse (Brechin et al, 1998; Davies, 1995; Meerabeau, 2005; Roberts, 2000; Traynor, 2004; Williams et al, 1992) especially in relation to the medical profession (Brown and Jones, 2004; Fletcher, 2006). The supposition that the dominant societal, organisational and medical paradigms legitimise a propensity for andro-centric comparison and privilege has generated a vast amount of research implying that nursing is an oppressed and powerless group; a *semi-profession*, (Hall, 1999; Roberts 2000; Traynor, 2004) whose

decision-making capacity is disregarded by health care managers (Salvage, 2001).

Academics consider nurses are disadvantaged in their own profession believing their work is trivialised and undervalued because they are female (Corby, 1997; Davies, 1995, Fletcher, 2006; 2007; Hallam, 2000; Holloway, 1992; Lane, 2000; Mackay, 1992; Melia, 1987; Salvage, 2006; 1985; West and Zimmerman, 1991; Wilson, 2002). The inter-discursive integration of a feminine discourse into the 'unity' for nursing is thus evident, but in post-structuralist terms should be challenged in the way it reinforces difference, especially as studies fail to provide any conclusive evidence of a differentiation between masculine and feminine characteristics (Eagly and Johnson, 1990; Powell, 1988).

Nonetheless, nursing is historically constituted by a vocational image, where material conditions are judged unimportant, almost saintly, sacrificing their needs for the good of others, akin to motherhood, essential, with its own intrinsic rewards and deemed the polar opposite of medicine as logical, clinical, scientific and masculine (Bilton *et al*, 2002; Melia, 1987; Short, Sharman and Speedy 1993; Wagner, 1993; West and Zimmerman, 1991; Wood, 2000) but whether nurses actually see themselves oppressed because of the gendered orientation of the role is inconclusive. There is nothing in the 'grey literature' (Nursing Times, 2006) about this subject suggesting that feminine oppression is not foremost in the minds of everyday nursing practice. What is evident, however, is that predominantly the composition of nursing is female and its femaleness does seem to perpetuate in the recruitment literature (Cardiff University 2006; Davies, 1995; Hallam 2000; NHS Employers, 2005 Sherrod, Sherrod and Rasch, 2005; Smy, 2005; Cullen *et al*, 2003).

### **Nurses in Health Care Management - *La Belle et La Bete***

My exploration of the discourses of nursing and managerialism reveals a discontinuity with regard to their constitution as discourses bear very little relation to one another, which perhaps my exploration serves to reinforce rather than challenge. This is fascinating as many nurses 'manage' their day-to-day activities, or have made the 'transition' into senior management roles

(Kowalczyk, 2002). Currie (2006) perpetuates difference by suggesting a perturbation within the nurse self is possible, wrought by the interaction of supposedly two oppositional discourses, one rational, functional and scientific and the other empathetic, caring and socio-centric. The literature regarding nurses and management is vast but my interest is in the permeability of each concept, the extent of inter-discursivity between the discourses that comprise the field of management and the field of nursing, allowing me to challenge the distinction and to inform the reader that difference is not as straightforward as one might think.

On the one hand, we have an article by Persson and Thylefors (1999) that suggests nurses need to change their 'identity' from a nurse to manager when they take on a management role and Currie's (1996) research concludes that this expectation conflicts with their professional dispositions. Westmoreland (1993) even suggests that the transition between nursing and management can be *painful*. Research also cites the belief in the need for nurses to adopt the dominant paradigm that management theory advocates (Currie, 1996; Maddock and Morgan, 1998; Marquis, and Huston, 2006; Roussel, Swansburg and Swansburg, 2008) and yet the relational skills and their socio-centric beliefs of nurse managers are emphasised (Currie, 1996; Westmoreland, 1993). Sambrook (2006) considers that managers and nurses are stereo-typed resulting in the assumption that if you are a good nurse you're not necessarily good at business, but her results conclude that nurses do make that transition, adapting their self with little difficulty.

Davies (1995) notes that in health care the dominant management norms remain 'masculine', but argues that the image of rationality is largely an illusion as much of the work in the healthcare context would not be successful without the embodiment of emotionality, a notion supported by research that argues that managers do not necessarily conform to the rational notion of management (Mintzberg, 1990) and respond idiosyncratically to organisational and political discourse (Young, 2000). An article by Connolly and Jones (2003) reveals that managers based in health and social care service settings exhibit differences and similarities to each other, but that managers with a clinical or social care

background, tend to retain their underpinning values of empowerment, support and respect of clinicians. Young (1999) adds that managers with a nursing background are more versatile and opportunistic and are less likely to use rule-based processes, suggesting that morality influences whether rules could be broken or not.

However the notion of traditionalist management in nursing is not unimaginable. Salvage (1990) believes that nursing self legitimises the hierarchy of structure in health care by virtue of their socialisation in the system and this suggests that the self will accept or tolerate the rational authority of senior colleagues. Hewison and Stanton (2002) contend that the impression that nursing and management represent antithetical positions is misplaced as there are similarities, especially with regard to grasping 'quick fixes' and the need to pursue a more scientifically rigorous approach to practice. This may be borne from the dialectic assumption that professionals tend to focus on the local rather than organisational concerns (Harrison and Miller, 2002; Mintzberg et al 1987).

Another premise is that focus of non-clinical managers is at variance with clinicians and that clinicians do not wish to be involved in organisational management (Carney, 2004a; 2004b; 2006; Wells, 1998) but Carney's (2006) research concludes that non-clinical managers do demonstrate values that orient around a caring and ethical approach and perceives that clinical-non-clinical strategic interaction is optimal when values correspond. Currie (2006) argues that nurses should be more involved in the strategic operation of health care, because of their ability to translate policy intention into contextually specific practice, but adds that constraints are placed on nurses' involvement both from the medical and political surfaces of health care.

Nurses suggest the reason to get involved in management is for personal growth, to make a difference to service quality and to add social value (Maddock and Morgan, 1998; Westmoreland, 1993) and to improve the clinical environment (Thomas and Matthews, 2006; Thomas, Liddle and Matthews, forthcoming). However, their discursive practice is caught midway, perturbed by the need to provide care within economic constraints (Persson and Thylefors, 1999) but

tending to adopt the more accepted efficiency driven focus of the bureaucrat (Maddock and Morgan, 1998).

Studies reveal that nurse managers experience ethical dilemmas in balancing the cost versus care equation, especially in their need to harmonise the expectations of the service and the traditional moral standards of the clinical 'work ethic' (Cooper *et al*, 2002; White 1986) perhaps reflecting how the self continues to ascribe with the caring and patient-centric ethos, a disposition historically wrought perhaps by virtue of their nursing experiences, but as stated this is not to suggest that non-clinical managers do not feel likewise. However, anxiety is clearly voiced as nurse managers consider the field of management a separate and adversarial camp from nursing, manifesting in a loss of camaraderie, the feeling of being caught between clinicians and administration, *the meat in the sandwich*, (Thomas and Matthews, 2006) where abuse and resentment from subordinates, doctors, families and superiors leads to feelings of isolation and loneliness (Gardner and Gander, 1992; Persson and Thylefors, 1999; Silveti, 1990; Westmoreland, 1993).

#### Discourses Surfacing in the Field of Medicine - *Doctor in the House*

*"In medicine there is no simple organised set of discourses that unified the field. The field of medicine is replete with hypotheses of its own; "hypotheses of life and death, of ethical choices, of therapeutic decisions, of institutional regulations, of teaching..."*

(Foucault, 1972: 37)

This quote by Foucault clearly identifies the clinical, ethical and moral priorities of medicine and it is one that remains explicit in the academic literature, where clinical research and comment is immense and massively outstrips any political and organisational concerns. It is said that the essential skill of a clinician is the ability to gain rapport with the patient to elicit significant findings and to interpret these into an appropriate diagnosis, usually using therapeutic models based on expert clinical opinion and method (McWhinney, 1997) and suggests how a discourse of science needs to be balanced with socio-centric and relational discourse. However, the profession is thought to be at a critical

juncture (Black, 2006) pushed from its position of equilibrium by political interference, advancing technology, consumer expectation and competing demands; “*doctors face uncertainty yet customers want certainty*” (Black, 2006:110)

### **The Historical Emergence of a Medical Discourse - *Hearts and Minds***

Foucault (1973) reveals, in the *Birth of the Clinic*, the way in which the medical profession emerged with the growth of the, then, ‘medical market’ of the eighteenth century, to become trusted and well-respected pillars of society. From a political perspective the field of medicine conveniently and simultaneously traverses two discursive spaces, the pathological space and the social space and in the eighteenth century the social space was revealed as being far more valuable to an emerging capitalist and modernist agenda (Foucault, 1973). L’Avernière (1789) considered doctors as *priests of the body* able to engage with an entrusting public to disseminate a discourse that associated health with moral living (Foucault 1973: 32). We might consider that this reflects Foucault’s concept of *pastoral power* (Dreyfus and Rabinow, 1986) where a ‘religious’ beneficence transcends into health and well-being through the role of the doctor; a bio-political power that aims to lead to the *care of the self* (Foucault 1986), a notion still endorsed in contemporary healthcare policy (Department of Health, 1999).

The illusion existed, and still does, that healthy living would eradicate disease and hence the need for hospitals; “*gradually in this young city entirely dedicated to the happiness of possessing health, the face of the doctor would fade...*” (Foucault, 1973: 34). The objective was to de-centralise medical care to the community, which I must admit gives me a distinctly uncomfortable feeling of *déjà vu*. How wrong this ‘hypothesis’ was, the medicalisation of motherhood, madness and sex and diseases of industrialisation met with the diseases of excessive living and countered political aspirations and in contemporary society medical jurisdiction now exists from ‘the cradle to the grave’ (Fitzpatrick 2001). The consequence is that we now have approximately 130,000 registered doctors in the UK practicing in 57 medical and surgical specialities (DOH, 2006), the hospital service continues and contemporary health policy (DOH,

1999) continues to sing to the tune of health promotion through political rationality that self-inscribes the normative regulation of lifestyle into the public.

### **The Emergence of Specialist Knowledge - *Look Who's Talking***

A major transformation in medical discourse began with the revolution in medical treatment and surgical techniques, during the Victorian era (Robinson, 2001); medicine began to emerge not just to inscribe moral norms on an unsuspecting society but as a scientific discipline. With a monopoly over an increasing amount of medical knowledge, medicine became formalised. Regulated training, membership of the Royal Colleges and ritualistic ceremonies emerged, stating allegiance to the Hippocratic Oath, a symbolic gesture that forges a link with moral authority and trust, an outer image of honourable behaviour and the need to balance the excellence of science with art of compassion (Huber, 2003).

As Foucault (1980) explains; *“the extension of technico-scientific structures into the economic and strategic domain was what gave the intellectual his real importance”* (1980: 129) and a newly specialised body of clinical knowledge, their duty and responsibilities to the public and their self-responsibility for training and regulation (Klint, 2002) endowed the medical profession with a high degree of implicit power (Ham and Dickinson, 2008). The ‘icing on the cake’ for medical power was the emergence of a specialised vocabulary of anatomy and physiology that entrenched difference in relation to other powerful groups in society. The emerging gravitas of the medical profession shifted the balance of power increasing their ability to drive political discourse (Huber, 2003) and this large measure of autonomy continued until the findings of the Griffiths report (1983) recommended the introduction of ‘professional’ management.

The power of specialist knowledge is located in its uncertainty of task making codification problematic (Hallier and Forbes, 2005). It is considered that a large proportion of clinical knowledge is tacitly held and transferred through apprentice style training, that clinicians seek to perpetuate, creating the context where clinical practitioners are able to protect their autonomy from outside



interference (Sutherland and Dawson, 1998), but that ‘modernisation’ seeks to capture in procedures and evidence based guidelines.

It contrasts nursing, where nurses have tended to collaborate with the rationality of codification, thus routinising their own skills and thus making the delegation to less qualified staff less complicated (Sutherland and Dawson, 1998). Foucault would have recognised I am sure how the authorities who speak for medicine, such as the British Medical Association (BMA), are endorsing the validity of the evidence-based and systematic approach (McLaughlin, 2004) although McLaughlin argues that evidence-based medicine can also be deemed a persuasive tool to ration treatment and care in the face of ever increasing demand.

Thus the profession of medicine, historically viewed as one of high esteem, together with the nursing profession, became the gate-keepers of the NHS, but are more recently finding their voice is not influencing health policy (Dacre, 2008). The profession is now the focus of criticism from both the public and their peers (Davies, 2002; Smith, 2003) and moves are currently underway to diminish their self-regulatory power (DOH, 2006; 2007a; 2007b; Goodlee, 2006a; 2006b; Greener, 2006; Kmietowitz, 2006). It may understandable why it is reported that morale in the medical profession is low (BBC, 2007e).

### **Modernising Medicine - *Dr No***

Medicine, like nursing is multi-faceted concept that along with scientific allegiance harbours an intuitive and compassionate discourse that echoes the discourse of caring. Medicine is an art, a highly intuitive balance of risk and benefit that dissipates the rational and linear determinism expected by contemporary notion of clinical governance; *“Medicine is widely held to be a science, but many medical decisions do not rely of a strong scientific foundation, simply because a string scientific foundation has yet to be explored”* (McPherson, 1990:17). Medicine is a combination of scientific evidence, contextual conditions, patient desire and doctor preference (Cullum, Ciliska, Haynes and Marks, 2008), but clinical judgement and experience is perceived

today as medical latitude and is criticised by the rationality of managers (McPherson, 1990, Newdick, 1995).

Medical conditions are multi-dimensional, social, psychological and physical, but the modern tendency is to label patients as conditions, but patients do not necessarily fit or see themselves within those labels (Hassey, 2002). In a discourse of logic and reason the intuitive can be oppressed and yet in actuality what exists in medicine is intuition as the 'generator' of ideas and reasoning as the 'tester' of these new thoughts (Fricker 1995). However, the scientific *zeitgeist in health care* (Raine, 1998: 251) is the ordination of evidence-based medicine powerfully persuading the medical fraternity of the rationality of clinical decisions (McLaughlin, 2004; Sackett, Rosenberg and Muir-Gray, 1996) subjugating the art of medicine and relegating the lucidity and validity of clinical judgement, frustrating a profession who claim that the key dynamic of medicine is to first do the job, then to prove what has been done (Davies, 2006; Hunt, 2006).

Scepticism and resistance is now recognised in clinicians, who are being characterized as organisational villains (Garvin, 2004; Gollop *et al*, 2004; Sehested, 2002) and aggravating doctor-manager relations (Baker, 2000; Ploch and Klazinga, 2005; Som, 2005). The reluctance to embrace reforms stems, in part, from a dislike of the way change programmes have been imposed (Garvin, 2004). It is also thought that the compassionate, emotional and relational nature of medicine is also under attack by the businesslike focus and the proliferation of a contractual-like vocabulary (Fitzpatrick, 1999). Garvin (2004) contends that clinicians are motivated by different incentives to managers and argues that doctors see endless streams of conflicting initiatives appear, fail and then reappear under a new name.

In addition to challenging the boundaries of clinical judgement, the doctor's role is also being perturbed from a managerial direction. The NHS Plan (2001) considers 'skill mix' a major issue for health care services, which politicians state, if handled appropriately, can increase productivity and improve the quality of working life and accordingly the medical profession is coming under the

onslaught of what has been called *proletarianisation* (Child, 1982b: 212) and *McDonaldisation* (Dent, O'Neill and Bagley, 1999). Wanless (2002) considers that nurses could take on 20% of the doctors work, even though nurses would prefer not to do a doctor's 'discarded work' (Alcolado, 2000; Banham and Connelly, 2002) but the scientific and linear re-engineering of activity threatens a systematic de-skilling or *de-professionalisation* that doctors fear (Dent, O'Neill and Bagley, 1999). In addition to managerial discourse de-professionalisation is being seemingly aided by convergent discourses that attempt to simplify the complexity of medical practice, as recognised in clinical governance, changes to medical regulation and accreditation, Modernising Medical Careers, the Consultant Contract (Greener, 2006; Harrison, 1998; Rogers, 2002; Tooke, 2008; Walshe and Benson, 2005).

The consequential shifting status of the profession, driven by the political critique that professionals are self-serving and wasteful, endorses managerial interference and subjects clinical activity to performance appraisal (Bolton, 2004; Hallier and Forbes, 2005). Ian Bogle, the retiring chairman of the BMA, in 2003, made a scathing attack on the government initiatives, describing "*the creeping morale-sapping erosion of the doctor's clinical autonomy, brought about by micro-management from Whitehall*" (Seddon, 2005: 211). Seddon (2005) argues that guidelines and protocols that diminish professional responsibility and promote 'production line' values would stifle innovation and is further and more worryingly associated with increasing clinical risk (Seddon, 2005). This in turn generates the need for further official guidelines to counter the dilemmas prompted by de-skilling. The National Institute for Clinical Excellence (NICE) (2007) *Clinical Guideline 50* provides a suitable example.

Modernising Medical Careers is another political initiative, negotiated through the BMA that shifts the balance of power away from the Royal Colleges and is angering both doctors and students (Bosely, 2007; British Broadcasting Association 2007c; 2007d; BMA, 2007a; Hall, 2007). The Consultant Contract (BMA, 2007b) similarly adjusts the balance of power by attaching a "*time value to programmed activities*" with the aim of providing "*greater transparency around the level of commitment expected by consultants*" by prescribing the

level of time consultants should devote to “*direct clinical care*”, a term that excludes the dimensions of teaching and research as an NHS activity (BMA, 2007b).

### **The Perception of Doctor – Manager Conflict - *Star Wars***

My earlier comments (Baker, 2000; Garvin, 2004; Plochg and Klazinga, 2005; Som, 2005) with regards to aggravated doctors-manager relations suggest a simmering conflict between what aspects of health care should be prioritised. However, the dominance of the clinical and professional prowess of doctors is still seen to challenge the performative rationale of managers (Hallier and Forbes, 2005; Harrison and Lim, 2003; Harrison and Pollitt, 1994; Kowalczyk, 2002; Maddock and Morgan 1998; Winyard, 2003), perpetuating a dichotomy of opinion, *the two tribes* (Hunter, 2002).

The ability to engage doctors in management is critical for the implementation of NHS reforms (Dacre, 2008; Edwards *et al*, 2003; Thorne, 1997). Ong (1998) contends that doctors do welcome the opportunity to influence hospital strategy, even though these activities can be burdensome if added to their clinical workload (Hearing *et al*, 1999). Research suggests that progress has been made in appointing doctors in leadership roles where evidence indicates that their sensitivity to the nature of medical work reaps benefits in terms of quality improvements (Ham and Dickinson, 2008).

The perennial perception is that doctors and managers have different worldviews, different sets of values (Edwards *et al* 2003; Hunter, 2002) or competing ‘ideologies’ (Connelly, 2004). Doctors are assumed to work in the best interests of individual patients, whilst it is considered that managers have a collectivist outlook, an outlook that counters the notion of clinical autonomy and individualism (Hunter, 2002). Smith (2003) believes that doctors should think more strategically, like managers, but Edwards *et al* (2003) consider that their differing perspectives should remain. Owen and Phillips (2000) however refreshingly challenge the demarcation line between doctors and managers, arguing that this is too rigidly defined and that the two parties do present similar values.

Hallier and Forbes (2005) suggest that doctors in management positions tend to reduce the delineation between management and clinical activities and, even though they do not always have the support of the colleagues, show a continued focus on clinical activity, sometimes with objective of undermining management. The authors consider that the way in which individual doctors accepts a managerial perspective is dependent on whether previous 'management' experiences have confirmed have or contradicted their expectations. Viitanen *et al* (2006) argue that doctors in management, in Finland, perpetuate the clinical privilege, but should reconstruct their 'orientation' and act like managers.

However Thorne (1997) reminds us that historically doctors have always managed activity and the decision-making process within the clinical domain, it is only managerialism that has separated this into a new functional role. Perhaps the creation of clinical directorates attempted to re-align this 'diversity', giving doctors the responsibility for directorate expenditure and thus unconsciously inculcating the economic imperatives of management into the medical self; driving into the very 'soul' of the clinical agents (Sutherland and Dawson, 1998).

### Portraits of the Participating Context - *Sliding Doors*

To explore the participating study site in more depth I found the urban sociologist, Jacob's (1993, orig. 1961) critique of modernist city planning provides an inspiring correlation with which to shift the ontological lens to the micro-level and emphasise the subjectivity of system agents. Jacob's (1993) contends that agents who come into daily contact with an environment see it from a completely different angle to those who may pass through or read about it and that naturally their perspective differs.

Jacob's explains that pedestrians have a completely different view of city life compared to drivers and argues that so easily drivers are thought of as the villains. You may be a step ahead of me in translating the notion of the 'villain' in healthcare organisation, but what is important to recognise is that

perpetuating this dialecticism does not advance our thinking about management practice. Hence I attempt to portray a more balanced view of the participating Trust from three horizons, the Trust's public face, the workforce perspective and the 'visitor's' perspective.

### **The Trusts' Public Image - *The Godfather***

Located in South Wales, the Trust's public face portrays itself in a performative manner that both mirrors and ratifies the political agenda in Wales. Both their Annual Report (2006-2007) and their website describe the Trust as one of the largest NHS Trusts in the UK, with a budget of over 600 million and over 13,000 staff. Providing services to around 500,000 people, they state their mission as promising to "*achieve excellence in providing safe, effective, efficient and compassionate care*" and profess that their staff are their biggest asset and the key to achieving these goals.

Services are divided into several directorates, medical, surgical, mental health and paediatrics and community, each of which is subdivided into more specialist fields. It is a misconception that a NHS Trust is merely located on a hospital site(s) as the Trust provides a growing range of community-based services and new therapies as alternatives to hospital admission. In ontological terms the Trust is describing a human system within a larger eco-system that cannot disconnect itself from the social community that they serve.

The Trust's financial performance is prior in the Annual Report and I ponder if the WAG, rather than the public, is its prime audience. The report reviews "*activity and successes over the past financial year*", in what they say has been "*a tough and challenging financial climate*" and assert that their cost reduction programme has been "*successfully delivered*" and in true heroic fashion suggest this financial achievement is due to "*concerted management action and control*". The Trust describe how their ten year plan will strive to achieve further reductions in waiting times, improve staff *experiences*, and improve the *fundamentals in care*. The report describes how Trust activity has increased with developments such as the inauguration of nurse-led units to advances in IT. The Trust suggests the need to improve *staff experiences* even though they state job

satisfaction is high and state that; “*we listen to their views on why they like working here*” silencing any alternative notion of ‘dislike’ to an observing audience.

The Trust is evidently sensitive to the impact of societal rights and demands and the website focuses on providing clear and formalised information for the public on freedom of information, data protection and directs the public to the Health and Social Care Guide for Wales; (WAG 2002) a document that expands the ‘patients charter’ into social care and describes the services that the public should expect to receive. Difference is reinforced through the website, that ‘speaks’ proudly of their clinical staff, who play a unique role in the teaching of doctors, nurses and other therapists, and comprise some of the best clinicians in their field, constituting a centre of excellence for many specialist services. The existence of a ‘Staff Charter’ appears to formalise this commitment.

### **The Participants Perspective - *How Green Was My Valley***

As my respondents relate their experiences, they paint a picture of the Trust that again resonates with Parkers metaphor; “*maddening complexity*” as each, describes an organisation rich with interacting agents (4, par 140; 7, par 161) who have an almost love-hate relationship with the field of secondary care (2, par 312; 5, par 440, 588). The emotional aspects of health care are voiced as the respondents describe the Trust as *daunting* (5, par 568) a *battleground* (8, par 213) a *political hot potato* (3, par 53) a *safe haven* for patients (3, par 39) a *maze* (6, par 338) a *five star hotel* (3, par 39) a *whole town* (7, par 173) and a *black box* (7, par 67). The latter implies some enigmatic, possibly Pandoran, dimension of health care in which its complexity is hidden, abstracted from the reality, a box from which the lid perhaps should never be lifted for fear of really seeing what’s inside. In effect, I reflect how the Trusts public image consolidates this abstraction; one does not need to know the complexities of its working environment to be part of it.

Participants’ accounts depict co-existing, but bounded, concepts, acute care, mental health, local authorities, primary and social care, an operant layer of service provision sandwiched between a political and public voice. The term

*political hot potato* infers how the reform of health care is a juggling act to entertain the aspirations of politicians and the votes of Welsh citizens. However, the term *battlefield* expresses the problems cast by finite and fragmented funding, the difficulties of harmonising clinical priorities with the commissioners' requests for services; "*we are in a long term relationship with our commissioners...we need to assist each other through the various hurdles of the NHS*" (8, par 64) and the existence of; *competing interests* (7, par 160). Interestingly their tales reinforce differentiation whilst simultaneously challenging the boundaries by asserting the need for interdependency and cohesion within a demographically challenging world (3, par 174; 7, par 121)

The Trust is portrayed as a dynamic, interdependent and evolving entity (4, par 229; 5, par 473; 7, par 249) where reform is continual and driven through political discourse (5, par 520-544, 568), but anxiety and frustration is voiced arguing that; "*if the Government changes it will all be turned on its head*" and "*we don't know what the future holds*" (7, par 90). Another claims the "*organisation is going through a radical shake up*" and is *struggling* against continual change; "*we felt like a big liner in the dock struggling to turn around, to sail off... we don't seem to be able to turn that corner and move on*" (5, par 564). This nautical metaphor is one that I have heard frequently but I'm never sure what to glean from its application. Comments vacillate between the positive and the negative; "*the downside is that its so big...there's a loss of personality at individual level*" (7, par 160) and "*it's quite daunting because there are huge issues we are dealing with*" (5, par 588), but any critique agents make is frequently contrasted with statements contending that; *it's a lovely place to work* (5; par 588) and that "*you've got some great peers and some great leaders, its just so hard to work out who every one is*" (7, par160).

Of interest is that all the respondents describe the Trust in dichotomous terms, echoing the fracture expected of a hierarchical organisation; the terms *we* and *them* delineating between *they* the managers and *we* the clinical staff, and the statements of clinicians create the perception of a web of management poised in a position of authority. The fracture is further enhanced by stories that emphasise and thus reinforce difference between clinicians and managers;



stories that indicate a wry expectation of a managerial aptitude; “*managers do not have any more answers that I do*” (6, par 258) and the need for; “*more doctors involved in management*” (8, par 175). Stories from the nursing staff also emphasise the existence of a nursing hierarchy that runs a concomitant but parallel course to the management structure, layers of ward managers, senior sisters, chief nurses and directors.

The Trust is also described as fragmented into many networks, where abstract boundaries are constructed to *protect* (8, par 44) their environment, a profound metaphor that implies a degree of threat and anxiety. Respondents emphasise the ‘silo’ nature of the wards and theatres, *protected* from the management levels, but argues that this generates cohesion, solidarity and team working, but their belief in interdependency is expressed throughout. Delineation is also revealed by accounts of the Trust through the day and by night, where the lack of specialist nurses and managers at night retains an organic way of working that differentiates markedly with the day time, where nurses “*work[ing] completely in isolation*”, but are clearly able and expected to “*think on [their] feet*” (2, par 8). The comment that; “*I think the experiences working nights are second to none, because we had to think what action could be taken straight away*” (2, par 8) emphasises that at night there is a climate of mutual authority, responsibility and decision making that continues regardless of Roy Griffiths’ estimations.

### **The Author’s Perspective – *For Your Eyes Only***

I feel a sense of both trepidation and excitement as I enter the hospital to interview my first participant. The sky is grey and several ambulances fill the bay in front of Accident and Emergency, double-parked, simulating the notion of drama, frequently as I recall, absent in reality. The café area is busy, some in wheelchairs, parents with children, staff, some in uniform, others in ‘scrubs’ queuing for coffee. I think of the hazards of infection; institutionalised thoughts? The corridors and lifts are the same; people everywhere. I share the lift with a couple of young men in ‘theatre blues’ each trying to impress with their clinical language.

At ward level I ring the bell, a nurse in a navy uniform opens the door simultaneously persuading an elderly patient not to leave; she calls her by name. The ward is busy, a lady is clearing dishes on a trolley and another mops the floor lethargically. A nurse exclaims that a team from the Community Health Council has arrived unexpectedly. I can hear the phone ringing, ringing, ringing, but within the notion of chaos there is an impression of ease, as if it is all in a day's work.

I feel a sense of loss; the hospital environment had been my second home; perhaps my first. The office is dingy, cluttered with files, handbags, equipment and an aging PC; it rekindles memories. During my visits I notice how it contrasts starkly with the manager's accommodation, located in a separate block from the main hospital, quiet, almost deserted in comparison, homely, adorned with family photographs, pictures and potted plants among the stacks of files and documents; a fitting tribute to bureaucracy I thought.

However, everyone I encounter, participants, managers, clinicians, receptionists and car park attendants are helpful and at ease within their context; accustomed to the 'maddening complexity'. Maybe they do not see that image. Their informality of exchange is blended harmoniously with correctness, a manner with which I could reflect, pleasantly pragmatic. Each, like my self, occupied an abstract, but communal living space of cultural, social and professional norms, values and expectations that unconsciously constitute their 'workplace identity' what Bourdieu (1991) describes as the *normative logic* of their *habitus*.

I genuinely feel part of, not merely a social system, but of a family, my profession allows my membership, it's as if we all know each other, impossible of course. Through their stories a genuine connectivity surfaces between us, perhaps an unconscious acknowledgment of interdependency or maybe suppressing dissent in the face of a stranger, competent actors, repeating expected behaviour to the point to which it has become an unconscious act. I am here to explore their *habitus*, to reveal how its constitution is transforming in the evolving field of health care in which they work.

## Conclusion to the Chapter

This chapter serves to elaborate the intricacy, heterogeneity and richness of the discourses that constitute the secondary care context and by doing so demonstrates meaning in Parker's (2004) adage of 'maddening complexity.' The latter section also introduces the organisation in a more passionate and emotional timbre that the mechanistic and factual portrayal on the website tends to silence. In my mind these diverse perspectives allow me to understand that that two potentially oppositional discourses are operating inter-discursively within the same system. The rationality of their public image merges with organic reality through the stories of agents.

My archaeological exploration into the discursive constitution of the secondary context raises two further thoughts. Firstly, the discourses that inform each conceived 'unity' demonstrate that unification is a flawed concept in reality, as every piece of scholarly writing or thought introduces a slightly modified and new perspective of a concept, thus spontaneously modifying its definition and challenges the boundaries that attempt to engender difference. The inter-discursive mess is the symptomatic outcome as discourses from many surfaces of emergence mutually interact, at all scales of the system, co-evolving over time and with practice, challenging the difference that dominant discourses attempt to sustain. This interaction is an unsettling dynamic, a perturbation that, as the literature suggests, can generate frustration and anxiety, but discourses will never cease to evolve on their transformational path.

The chapter by attributing particular discourses to particular unities demonstrates the trap of perpetuating discursive closure. As author I inadvertently reinforce closure through dominant bodies of referential knowledge as one concept attempts 'the will to truth' (Neitzsche, 1910) by the inclusion of some claims but the exclusion of others from its definition. However, I hope that throughout the chapter I have gone some way to challenge the closure using evidence that reveals the permeability of conceptual constraints.

My second point is that I objectify an affirmation both in the literature and in my own experiences that dominance and closure is visible, that discursive transformation is being driven in a particular direction. I consider that the balance of discursive interaction is weighted by the rationality of science, cascading from a politically dominant level and defining the object of health care in performative terms. I consider that political attempts to address the politically defined performative reality operate through the discourses of managerialism and clinical governance, (re)validating clinical practice through a particular lens that attempts to order and control its complexity and messiness by fitting the idiosyncrasies of both agents and patients into processes based on rational and linear thinking.

It may be that political conceptions are just and I do not argue against the need to balance the cost-demand equation, but I am concerned about the methodological assumptions adhered to in their discursive operation, especially if attempts to control agency subjugate or exclude the voices of clinical level experience, intuition and desire, which in turn could ultimately impact of the need for flexible practice and patient safety. Thus my next chapter turns attention to distinct relationship that managerialism forms with other unities and the underpinning knowledge that informs these seemingly modernist discourses in an attempt to move management thinking beyond the modernist doctrines of control and conformance.

## **Chapter Three**

### **Moving Beyond Modernism**

#### ***-The Forbidden Kingdom***

## Introducing the Chapter

*“How come when I want a pair of hands, I get a human being as well?”*

(Henry Ford (unknown) in Lewin and Regine, 1999: 11)

This mocking comment, attributed to Henry Ford, epitomises the problematic of human agency and the frustration of the modernist mindset in its misapprehension of the need to, or the ability to, control agency. This is significant, because the way in which managers conceptualise agency crucially underpins the assumptions and approaches of their discourse.

The previous chapter explored the discursive underpinnings of managerialism, as rational, mechanistic and determinist in its aspiration to control and standardise agent behaviour by attempting to remove their diverse and idiosyncratic character. However, this dehumanising and functional philosophy appears to stand counter to the political desire for a secondary care organisation as flexible, innovative and safe. As Reed (1989) cautions the power of agency can result in the constraint of human bondage.

The focus of this chapter is therefore the search for an intellectual framework for my context that looks beyond the assumptions of mainstream management theory to one that can embrace the ambiguity, instability and emotion innate in a complex human social system such as the acute hospital sector. In seeking a new frame of reference, this chapter draws from a body of knowledge that shapes the discipline of organisational behaviour, contemporary sociology (Bauman and May, 2001; Reed, 1989), raising ontological and epistemological questions regarding the limitations of the realist paradigms that motivate and dominate modernist conceptions of the organisation, agency and social order, opening our eyes to alternative ways of thinking about management (Bauman and May, 2001).

To progress a more fluid and diachronic ontology I found Jacob's (orig. 1961) critique of modernist urban planning *The Death and Life of American Cities* inspirational in stimulating an alternative conceptualisation for my context. In parallel to mainstream organisational theory, Jacobs explains how the city has

endured a process of reification, boundaries drawn to simplify its complexity, to secure stability and in many ways security. In reality, there is no definitive city, its boundaries are fuzzy, morphologically it is a network of people and practices, clusters of relations embedded within and interacting with each other; diverse, dynamic.

Jacob's text initiates a new way of thinking that integrates with the profound insights from Complexity Theory, in particular, the concept of Complex Evolving Systems (CES) (Mitleton-Kelly, 1998; 2003a). To align a sociological model with Complexity I explore the conjecture of post-structural theorists, in particular the thoughts of Foucault, Derrida and Bourdieu, to offer a convergent and relativist perspective of agency that whilst evolving in parallel with the field of complexity, reflect many similarities and allows me to generate a unique epistemic understanding of agency within the CES.

The conceptualisation of self as the 'motivator' of agency is a crucial and fundamental parameter with which I challenge the futility of managerialism. Limitations exposed, the chapter explores the philosophical perspectives of post-structuralist scholars to progress the concept of self away from the functional and constructivist episteme to a fluid, reflexive and contingent conceptualisation that fits the co-evolutionary perspective of CES, thus presenting the thesis with an opposing intellectual perspective of 'social order'.

### Defining the Notion of Social Order – *The Dirty Dozen*

*"If dirt is matter out of place, then perhaps disorder is order out of place*

(Douglas, 1991 in Parker, 2004:171)

Douglas's quote about order, at first reading, appears enigmatic, but as we move through this chapter its bizarre significance will hopefully become more transparent. As a fundamental expression used throughout this thesis, I need to explore the notion of 'order' as one's ontological understanding of social order can hold the key to revealing the expectations and assumptions of managerialism.

One might consider 'order' at the opposite end of the spectrum to chaos. One also might consider it is a completely abstract notion or the manifestation of deterministic planning or design, so my difficulty with attempting a working definition of social order starts by expounding how diverse worldviews have differing thoughts about what order ought to be.

Parker (2004) contends that viewing 'order' through any single lens is acutely misplaced. For example, the vision held by the World Bank of 'social order' in Third World countries is generated in their own terms of economic stability and growth (Potter, 2000). The work of Picasso also provides an admirable example to elaborate on this concept, as his tortuous and dislocated images can make an onlooker feel uneasy with its' perceived lack of order, but it depends on what you expect to see; when is matter 'out of place'? For example, once you realise that Picasso's portrait of *Les Demoiselles d'Avignon* depicts his anger at contracting syphilis from a prostitute, his displaced and almost 'ugly' portrayal of the female form (Anon, 2008) inspires a new way of thinking of how he perceives the female form through the pain of a chronic and debilitating condition; an alternative perspective of order.

McMillan (2004) comments that disorder has it's own kind of order and this is supported by Parker (2004) who expresses that although many concepts of an ordered reality exist concomitantly, management discourse creates a privileged view, subjugating any alternative localised patterning of norms as 'disorderly' behaviour. Parker (2004) elaborates how managerialism predominantly orders the NHS through a modernist lens, but argues that depending on which lens you use you can see different concepts of order. After a recent trip to Egypt it is amazing how disorganised order can look to an outsider. Foucault clarifies that 'order' is founded on one person's unique *system of thought* (Foucault, 1966: xvi), a single mode of ordering that creates coherence in a space of possibilities, but Parker (2004) warns, however, that once a privileged view of order is legitimised, it is easy to consider other 'patterns of order' as disorder and it is this assumption that is a major frailty of managerialism.



Weaver (Jacobs, 1993) contends that managers are misled by the dominant modernist notion of order in their organisation, failing to see a complex human system as naturally ordered. Philosophically, managers hence vacillate between stability and chaos and treat their organisation likewise, focusing on simplistic determination to create order from what is an already ‘ordered’ system. Thus the initial step in exploring our space of possibilities is to consider the underlying assumptions and dilemmas that present in realist perspectives of order and agency.

### **The Underpinning Ontology of Managerialism - *Gremlins***

The philosophical consequence of the ordination of a work-orientated ‘culture’ coupled with the primacy of the capitalist and scientific doctrines through the ‘Enlightenment era’ created the misconception that the organisation is a closed and reified entity, detached from the world in which it resides, not part of the wider social system (McMillan, 2008). In reality this conceptualisation is merely a metaphorical and discursive construct that has become inscribed upon the self through time (Chia, 2002; Ford, 2004; Foucault, 1966; Harding and Learmonth, 2004; Richardson, 2005; Cillers, 1998).

This ontological illusion engenders a discourse that believes the organisation can be released from the influence of social, cultural, political and economic interference and that this freedom allows it to deterministically control agency and thus predict outcomes through stability and artificial order (McMillan, 2008). Agency is considered dysfunctional (Reed, 1989), the ‘gremlin’ of organisational order, characterised by “*the human ability to reason, to reflect upon their behaviour, their experiences and their environment...their capacity for conscious and self-conscious thinking and creativity and to behave independently of the defining constraints of society*” (Bilton et al, 2002:16).

Weberian discourse, recognised in the previous chapter as a dominant discourse in managerialism, is grounded on the ontological assumption that an agent naturally consents to the will of others, for some reason other than fear (Grey, 2005) and led to the assumption that they would logically conform to the overtly functional and technical discourse of *instrumental rationality* and *rational legal*

*authority* (Weber 1978). Managers consequently came to occupy a strategically dominant position and organisational structures sustained the relationship of power accorded to such positions (Reed, 1989).

The rational principles of scientific management is founded on the premise that agency must be eradicated (McMillan, 2008) and this discourse may have been successful in the exploitative performative philosophy of early capitalism, but is a philosophy of management that clings to the notion of hierarchical control and cannot accommodate the socio-political aspects of agency (Reed, 1989) that we might consider more visible in our 'post-industrial' or 'post-modern' world. Scientific management defines management tasks as functional and technical (Reed, 1989), where planning, organising and controlling is equated with designing out uncertainty and conflict to sustain the organisation in a perpetual state of equilibrium (McMillan, 2008; Reed, 1989; Streatfield, 2001).

Intellectual modifications, through systems theory, temper the approach of raw science in accommodating agency and interaction, through cybernetic control, the central tenet of which is control through self-regulatory mechanisms (Stacey, 2003a; Streatfield, 2001; Beer, 1981, Ashby 1956). As a philosophy considered pervasive in public sector managerialism (Stacey and Griffin, 2006) systems theory is recognised as the preferred philosophy of control in Welsh political policy (WAG, 2005).

The objective of the systems approach is to organise organisational relationships into a cohesive, scientific and predictable model that assumes that the constraints of the outside world can be removed or ignored (Boulding, 1956). The purpose of management is to objectively 'design in' the future state and to steer the organisation towards these goals through rational strategic planning and performance management. Whilst recognising unexpected outcomes and non-linearity systems thinking sought to remove these uncertainties by controlling innate human dynamics (Streatfield, 2001).

Although management discourse has therefore evolved in its appreciation of the interactive capacity of agents and the diachronic nature the system, this

discursive change retains the reified ontology; the organisation as a closed system of components where behaviour and interaction could be objectively controlled and where dysfunctional behaviour can be engineered out, thus increasing performative viability (Lyotard, 1984). However, when the complex human system does not respond as expected or yield the required outcomes the organisation reacts by creating more and more rules (Haynes, 2003) and in the NHS this may be recognised in the use of performance management and national guidelines. It is a discourse that attempts to silence the messiness of organisational activity (Lindblom, 1959; March and Olsen, 1976) and cannot accept that *“processes only appear to be messy and less than competent from the perspective of mainstream management thinking”* (Streatfield, 2001: 128).

### **The Epistemic Constitution of Agency in Managerialism - *Invasion of the Body Snatchers***

The epistemological position sustaining the macro-philosophical approaches of scientific management and cybernetics is realism; an objective belief that reality is independent of an agent’s interpretation (Richardson, 2005; Stacey, 2003a). Realism is deeply rooted in positivist science (Stacey, 2003a) whose hypothetical conclusions are reductionist, removing not only context, but contextual history, from the puzzle, isolating only particular aspects of the organisational complexity and thus synthesising generalist and linear notions of causality and predictability with which to exert control over agency (Craib, 1992; Potter 2000; Richardson, 2005; Sanders 1998; Streatfield, 2001). This encourages simplistic linear models of cause and effect such as the notion of ‘best practice’ guidelines (Snowden and Boone, 2007) omnipresent in public sector organisations; a ‘clockwork’ representation of agentic control.

The most critical aspect of realism, however, lies in its supposition that reality is stable, it denies temporality and evolutionary change and that the future is perpetually under construction (Denzin and Lincoln, 2003; Hospurs, 1997; Sanders, 1998; Prigogine, 1997). Positivism’s desire to develop universal statements however requires a stable object of interest (Richardson, 2005) and as a consequence realist models attempt create stability within the reality of a

dynamic and evolving complex human system; complex human systems and their ‘gremlins’ are eminently incompressible.

Of course, positivism may befit a stable environments where accurate information and clear cause and effect relationships exist, but it must be realised this philosophy falters rapidly as system complexity increases and its futility is exacerbated by any conformist mindset that refuses to re-negotiate any alternative perspective (Snowden and Boone, 2007). It is only in retrospect that complex systems appear simple, but this is not necessarily because they are stable (Cilliers, 1998; Kurtz and Snowden, 2003).

The futility of models of management structured on realist philosophy has been challenged for decades (Blau, 1955, Gouldner, 1954, Grey, 2005; Mintzberg, 1978; Reed, 1989). Realism attempts to ignore the non-linearity of human systems, the innate effect of micro-political processes (Reed, 1989) and the subjectivity of agents, how agents actually behave in accordance with their own norms and values, conscious and unconscious desires and in response to the subjective interpretation of every day life (Stacey, 2003). In health care, where external changes are rapid and information is not always available, it represents a mode of thinking that simply (re)generates past practice (Snowden and Boone, 2007) and potentially risky practice.

### **Exploring the Ontology of Self in Managerialism - *Pinocchio***

Whilst the discourse of scientific management requires the organisation to be de-humanised, managerialism also seeks to control pluralist tendencies through more subtle mechanisms of control that attempt to fashion the self, using a discourse of organisational commitment (Costa, Crump and Amiridis, 2008; Rose, 1999b). Philosophically discourse recognises that agents are not components of a ‘well-oiled machine’, but are often passionate and committed about their role (Grey, 2005), management becomes a social process geared to harmonising plurality (Reed, 1989) through a form of ‘negotiated order’ (Strauss 1963).

The hypothesis is that a cohesive organisational ‘identity’ drives agency towards organisational imperatives (Costa, Crump and Amiridis, 2008) and in the NHS the notion of ‘professionalism’ attempts to incorporate this human factor into discourse, making the assumption that an agent’s self, or ‘the minutiae of the human soul’ (Rose, 1999b) can be engineered to privilege certain social, cultural and organisational norms.

Agency is intricately and interdependently bound to the concept of self and the constitution of self has a profound influence on agent behaviour. The realist ontology assumes a dialectic relationship between societal [managerial] discourse and agency and offers a never-ending debate regarding this epistemological relationship between nature and culture. The duality is represented by two strands of opposing thought, the functional perspective and the social constructionist perspective (Craib, 1992; Lyotard, 1984; Whitehead, Moodley and Thomas, forthcoming) but neither truly fit the notion of the social system as dynamic and evolving.

The Structural-Functionalism model of Parsons (1951) asserts that agents act freely, but naturally gravitate towards the norms of social discourse and is premised on the essentialist or natural claim that agents are autonomous, primary and prior to the system, understand the basis of their own action and through the notion of logic and reason purposively function in complimentary roles for the general welfare of all, engendering a stable ‘societal structure’ (Craib, 1992; Lyotard, 1984; Taylor, 2001; Sarup, 1988; Stacey, 2003; Whitehead, Moodley and Thomas, forthcoming).

Structural- Functionalism provides an optimistic perspective of agency that implies almost existential concepts and teleological explanations advocating the concept of the ‘individual’ in Cartesian terms. The epistemological question that arises is, to what extent is an agent self-aware, the originator of his/her own behaviour. Where is the divide between voluntary and involuntary behaviour; consciousness and unconsciousness; body and soul; how does one determine the other (Juarrero, 2002).

However, Parsons' consideration that systems are evolving and self-regulating attracted my attention even although Parsons frustrates this position with a belief in the need for system equilibrium; stable systems cannot support the notion of evolutionary change or the idiosyncratic nature of agents, avoiding the arguments of subjectivity, self-interest and past experience (Schwarz, 1988).

In complete polar opposition is social constructionism, grounded in the notion of societal depth, an underlying structure of social cultural 'conventions' which although are not directly observable manifest in surface order and generate social practice to legitimise this order (Craib, 1992; Potter, 2000; Whitehead, Moodley and Thomas, forthcoming). In its base state, the social constructionist episteme represents an attack on the notion of the agent freedom and nature and is suggestive of social conditioning, where social constructs, perceived by the agent as natural and just, inscribe themselves on an agent's self, shaping their perceptions of knowledge, truth and reality. Locke (1694) used the metaphor of a clock, whose hands are tied to the 'inner spring', implying that action becomes locked in to a pre-existing set of rules (Hospurs, 1997) and not through subjective awareness or direct experience (Marsh *et al*, 2000).

A major deficiency of this epistemic perspective is the assumption that agents are unified in how they interpret social constructs and simply act in line with expectations, removing any notion of subjectivity or resistance. The process requires them to passively accept the logic of a normalised construct without resistance, assuming agents act without conscious thought, choice or any interdependent relationship with the system where reality is co-created (Bauman and May, 2001; Stacey 2003; Craib 1992; Jenkins, 2002; Sarup 1988). The structuralist concept falls further with its belief in a synchronic ontology, which does not account for thoughts, processes and actions being historical, changing with time and therefore similarly cannot accommodate the notion of emergence and transformational change (Craib 1992; Macherey 1965 in Sarup, 1988).

### **Midway on the Realist Continuum - *Frankenstein***

Understanding the limitations of the above models, the work of Giddens' (1984) attempts to conjoin the realist extremes positing a relational and interdependent

perspective of rules and agency in *Structuration Theory* where one influences the formation of the other. Whilst Giddens' thinking does advance the notion of society as continually evolving, paradoxically Giddens fails to see true reciprocity or the rules as continually evolving as Giddens' theory perceives a set of normalising rules which embed themselves in the self through the process of socialisation or *institutionalisation* (Craib, 1992). With reference to Wittgenstein's concept of *language games* Giddens explains novelty and unpredictability by suggesting that the rules are stable and explicit between players but that each game played is unique and thus the results are never predictable (Craib, 1992, Sarup, 1988).

The symbolic interactionist, Mead's (1934) concept of *social behaviourism* also proposes an interdependency between agent and society where the self is emergent and historically constituted by the social groups with whom the agent interacts and the way in which an agent interprets the actions of others. (Marsh *et al*, 2000). Grounded in the need for recognition and acceptance in society, the self orients around an agent's self-image, where an 'identity' is validated by internalising the values and beliefs of an 'ordered society' and is reinforced through practice, as non-conformity would render them excluded, marginalized and condemned. It is an assertion that reflects the notion of professionalism in its desire to create conformity to a homogenous 'identity'.

The assumption that agents are able to objectify a fixed understanding of their role is taken to new depths by Goffman's (1959, 1969) theatrical metaphor *dramaturgy* where agents act out their role in a theatrical manner. In some ways this is a credible concept that does fit agent behaviour, especially if we are considering the nursing role, for instance, but it merely represents one dimension of agency. Hoschild's (1985) concept of *emotion work* adds to Goffman's thinking, suggesting that tensions arise when the self is expected to modify its constitution to reflect a fixed social identity and intimates that one's core identity can be repressed at will, the *corrosion of self* (Sennett, 1998). Assumptions aside, this concept gains credence in the need to protect one's self from potentially deep emotional consequences of a particular role (Watson, 2002a).

Whilst I like to think that the health care environment with its ‘do no harm ethos’ fits many aspects of Mead’s thinking, especially the stereotypical conventions of professionals, the model is ultimately and profoundly limited by evidence that society and organisations are much more complex and diverse than the altruistic beneficence that social behaviourism suggests (Craib, 1992). Schwarz (1988) contends that agents are diverse and unpredictable, do not allow themselves to be slotted into a particular role and do not necessarily rationally and selflessly act for the good of ‘the organisation’ [or the ‘patient’] signifying that the ‘structure’ of society is not as ordered or stable as realists would like it to be (Craib, 1992) or managerialism needs it to be.

What an agent objectifies is subjective and can easily become confused or manipulated evoking (in)action that is quite unexpected. Mead’s (1934) suggestion is that the self is rational in its choice of discourse and thus agents can shift between alternative discourses from the multiple subject positions that they occupy and negotiate between them, but rationality is only one side of the coin, the self is open to more unconscious, intuitive, impulsive and emotional dimensions that cannot be ignored (Dent and Whitehead, 2002).

### **Summary**

Managerialism presents as a mix of realist discourses whose philosophical underpinnings simultaneously attempt to humanise and de-humanise agents through rational and mechanistic means, believing that practice can be strategically prescribed or be manipulated through the illusion of a cohesive organisational identity. This latter process is reflected in the adoption of the notion of professionalism in the NHS (Sutherland and Dawson, 1998; Wear and Aultman, 2006), where beneficent agent behaviour now aligns with organisational goals and not just those of the patient. Although this latter discourse contrasts the rational strategic fracturing of the ‘thinking’ and ‘doing’ levels of the organisation (McKinlay and Starkey, 1998) and implies a philosophy of emancipation, it remains a superficial discourse that continues to rely on the notion of control using shared values and personal development as functional levers of management (Costea, Crump and Amiridis, 2008; Pascale



and Athos, 1982) removing rather than accommodating the idea of the secondary care organisation as dynamic, messy and interactive with other socio-political systems.

What seems ironic is that managers fail to realise that the commitment-based philosophy is already legitimised by virtue of the allegiance to the dominant discursive unity in that field, locally negotiated and not prescribed by management discourse. The hospital sector has always been a highly bureaucratic organisation with a high degree of rational authority, but what has always existed at the operational level is a distinct level of autonomy and organicity that is able to locally legitimise a 'work ethic' to fit their context. I think Hood (1991) may be correct when ventures to say that managerialism would need to rely on the 'public service ethic', but managerialism may be in danger of weakening this commitment by prescribing and ordinating the performative imperatives of the organisation.

### Exploring an Alternative Paradigm of Social Order- *Alice in Wonderland*

*“The world we have created today as a result of our thinking thus far has problems which cannot be solved by thinking the way we thought when we created them”*

(Einstein, unknown)

My critique of the realist assumptions in which the discourse of managerialism is grounded sets a challenge to find a temporal ontology of the interactive and evolving human social system human that can reject the objective, hierarchical and boundaried models synthesised from realist and dualist sociological frameworks.

Cilliers (2008) explains representations become limited by their omissions and human social systems are complex systems with *more possibilities than can be actualised* (Luhmann, 1985 in Cillers, 1998:2) and cannot be represented by models that aim to compress the complexity into homogeneity and uniformity (Cillers, 1998; 2008; Richardson, 2005). Philosophical representations that deny

the ontological dynamics of human systems and that trace organisational phenomena by objectively examining the historical trajectories of single components cannot provide an accurate or predictable picture of current behaviour, let alone its future state (Cilliers, 1998; Richardson, 2005).

In seeking an alternative discourse for management I turn attention towards the theories of Complexity and the concept of Complex Evolving Systems (CES) (Mitleton-Kelly, 1998; 2003); an *explanatory framework that helps us understand the behaviour of a complex human system* (Mitleton-Kelly, 2003:24) by accommodating the dynamic nature of a human system and revealing how an alternative perspective of agency and social order emerges in a social system that relinquishes the need for the control based discourses of managerialism.

### **Restoring the Dynamic Ontology - Carousel**

Let me return to the work of Jacobs (orig. 1961) and her claim that it is the way people interconnect and behave that determines the characteristics of the city. The city is an emergent and evolving phenomenon, interconnecting and interrelating on a massive scale and is an ontology that immediately strikes a resemblance with my context, which is actually described as a *whole town* by one of my research participants (7, par 173); a clustered domain of relations within a larger social system. The NHS organisation is the people it serves.

Jacobs' (1961) critique of modernism is thus fascinating in the way it stimulates analogous thinking between the 'cityscape' and my context, as Jacob's ponders; "*Why do some cities flourish and others degenerate, even though billions are spent each year trying to reverse the decay*" (Jacobs, 1993: 5) and explores the factors that inspire economic and social vitality and what dampens these attributes.

Jacob's conclusions are profound and offer a suitable paradigm with which to begin my search for an alternative theoretical framework, recognising that diversity engenders the cohesiveness, mutual support and trust required for a self-maintaining community through informal relations, ensuring cities are

uniquely situated to solve their own problems by acting as self-regulating eco-systems.

Jacob's (1961) challenges the principles that shape modernist city design, arguing that modernist designers are guided by appearance and functionality and the disadvantage of modernist discourse may not be its aspirations but its myopic, rational and functional underpinnings; not observing how a city functions, but privileging preconceived ideas about how it should function. I propose that health care policy does likewise; genuinely espousing good intentions, but attempts to rationally design in what they think this organic system needs to flourish.

A fluid and networked morphology is generated in organisations as agents come and go over time (McMillan, 2004; 2008; Mitleton-Kelly, 1998; 2003a; Stacey, 2003); Mitleton-Kelly perceives organisations as differentiated patterns of nested subsystems within the social world; a scalar hierarchy of many focal points embedded on top of a complex societal eco-system, akin to a church, a school or a shopping centre, a point where a collective domain has emerged; a domain that may display and legitimise its own discursive unity and may well construct a privileged eco-system of its own (Jacobs 1965). What this morphology emphasises is the temporal and evolutionary nature of social systems; any impression of stability is mere illusion. As McMillan (2008) contends, the agents create the organisation; it is not the organisation that creates them.

Jacob's thesis draws from the pioneering work of Weaver (1948) who critiques the dominance of science in its inability to deal with the innumerable variables of the complex system and who argues for an ontological vision of *organised complexity* as a novel conception of system *organisation* that sits between *order* and what Weaver terms *'disorganised complexity'*, where behaviour is erratic or unknown (Weaver, 2004: 538-539).

Moving Weaver's ontology of 'social order' as 'social organisation' forward I turn my attention to the theories of Complexity, a plexus of discourses of

loosely defined principles that capture the ethos of pluralist interaction and a profundity of intellectual thinking with which to reawaken management discourse (Pascale, Milleman and Gioja, 2000; Popolo, 2008; Stacey, 2003) in a way that supports naturalistic interaction (Mitleton-Kelly, 2003a) and restores the elements of emotion and intuition to their rightful place (McMillan, 2004).

Complexity ruptures the universalist and iconic paradigm of classical science, displacing the clockwork perspective of modernism (Byrne, 1998; McMillan, 2004; 2008; Regine and Lewis, 2000). However, I must emphasis at the outset that my intention is not to apply complexity to the health care organisation but to argue that it is extant in every interactive human system, struggling to survive under the shackles of traditional management techniques.

### **Complexity, Self-Organisation and the Importance of Noise - *Butch Cassidy and the Sundance Kid***

I was instinctively drawn to the principles of Complexity Theory, as I recognised a philosophy of management congruent to my own management practice. As a young manager, I had committed the common mistake of believing that to manage meant to control, and yet I was acutely sensitised to the consequences it wrought, especially in terms of flexibility and commitment.

As Popolo (2008) suggests, it is capturing the ethos of Complexity rather than any finite definition that is important, but before I illuminate on the characteristics of a complex human system from a Complexity perspective I do present a simple and clear description of what I mean by a complex system;

*“A complex system ...is rich, dynamic and evolves over time. It is characterised not only by the elements (people and things) that make it up, but much more critically by the numerous and changing relations between those elements”* (Greenhalgh, 2000:514). However Wolfram (1993) explains that;

*“... the basic components and the basic laws are quite simple; the complexity arises because you have a great many of these simple components interacting simultaneously. The complexity is actually in the organization—the myriad of*

*possible ways that the components of the system can interact*” (Waldrop 1993:86).

It is this premise that makes me uneasy with complexity scholars who feel it worthwhile or necessary to scientifically model (Epstein, 2007; Miller and Page, 2007; Cognitive Edge, 2008; Venables and Bilge, 1998) or algebraically represent (Watts, 2004; Watts and Strogatz, 1998) the continual and co-evolutionary behaviour of complex systems. Models are objective and retrospective snapshots of temporary coherence constructed for deterministic predictability, merely *invented regularity* (Gell-Mann, 1994:227) every *blink* is believed a *wink* (Kurtz and Snowden, 2003) ostensibly missing the crucial point that complex models would evolve (Gell-Mann, 1994; Kurtz and Snowden, 2003; Parellada, 2002). I am sure however that Snowden would respond that identifying patterns would allow for the amplification or dampening of certain behaviours, but this assumes that this judgemental and supposedly objective manipulation could manifest in predicted outcomes and not veer the system into shadow or covert behaviour.

Complexity emerged from the non-linear mathematics of *Chaos Theory* (Gleick, 1993) the work on *phase transition* and *self-organised criticality* (Bak, 1996: Bak, Tang and Weisenfeld, 1987:381; Langton, 1990) the preoccupation in *Catastrophe Theory* of discontinuous change (Stacey, 2003; Taylor, 2001) and the pioneering work on *dissipative systems*, (Nicolis and Prigogine, 1989; Prigogine and Stengers 1984; Prigogine 1997; 2003). The prevailing principle in all these theories is *self-organising* behaviour, a process by which a number of individual agents spontaneously come together and co-operate in a co-ordinated manner (McMillan, 2004; 2008).

Lorenz (1993) recognises that self-organisation creates patterns of behaviour that orientates around an *attractor* state for that context; (Lorenz, 1993) “*an attractor binds a system to a pattern of behaviour*” (Mitleton-Kelly, 2003a:17). This does not mean that patterns can be predicted or determined, but that they will exist within certain confines (McMillan, 2004) producing a conceptualisation of order that reflects Weaver’s ‘organised complexity’, a mid-

point on the spectrum between chaos and stability. The notion of the *strange attractor* (Stacey, 2003), however elaborates that in any system the boundaries are permeable, the system is not closed and each pattern will be influenced by multiple attractor points, which pull in opposing directions and generate turbulence (Gleick, 1993; Mitleton-Kelly, 2003a). It is generating a perspective that acutely resonates with the health care environment and its multiple interlocking systems.

Prigogine's (1997; 2003) research in inorganic systems recognised strange attractors as 'noise', the micro-events or 'non-average' behaviour that destabilise a system towards a *far from equilibrium* position, a position of high perturbation, setting up an energy differential which in turn re-stimulates self-organising behaviour. Prigogine (1997) considers that it is the diversity and difference of the interacting components themselves that energise the system, creating an internal capacity for the system to move from one attractor state to another, adapting the pre-existing structure or organisation into a new order.

Prigogine's work is significant in demonstrating that system perturbation and disorder does not only destroy structure and organisation, but is essentially a pre-condition for its re-formation and its transformation (Taylor, 2001). System attractors ensure that system transformation remains within certain confines; a state of *bounded instability*, even though its actual trajectory is unknown (McMillan, 2004; Mitleton-Kelly, 2003a; Prigogine, 1997; Stacey, 2003a).

This portrays a picture of ontological fluidity where energy does not come from the 'outside' *per se*, as system boundaries are fuzzy, transient and permeable, but diffuses across many co-existing systems. What is important to grasp is that when a human system sustains a 'far from equilibrium' position it has the capacity to scan and reflect on the environment or landscape, sensing the strange attractors and the 'energy' that they bring, which threaten, perturb or motivate their attractor state. Kurtz and Snowden (2003) assert that the ability of a human system to recognise these *weak signals* allows an organisation to stay in a state of *anticipatory awareness* and, in this state of alertness a system, can amass several contingent strategies, micro-strategies, that allows the system to move in

either of several directions and thus explains why natural systems may manifest in unpredicted consequences (Mitleton-Kelly, 2003a).

Synthesising Prigogine's conclusions to a human system suggests that attempts to close and homogenise the system, to remove 'alien' disruption, by removing the diversity of agency through rigid rule-based or cybernetic control removes the energy differential and the system will settle into equilibrium, extinguishing the potential for spontaneous adaptation; the system stagnates (McMillan, 2004; Nicolis and Prigogine, 1989; Pascale, Milleman and Gioja, 2000; Stacey, 2003a).

### **The Concept of Complex Adaptive Systems Thinking- *The Italian Job***

The concept of Complex Adaptive Systems (CAS) moves Complexity into natural, living systems; weather systems, immune systems, biological evolution and even the behaviour of investors in financial markets can be represented by a CAS model (Gell-Mann, 1994). The CAS theorists of the Santa Fe Institute in New Mexico similarly observe the central characteristic of self-organisation in living systems, positioned in a 'far from equilibrium' state and that from a mass of seemingly random interaction regularities or patterns emerge. The patterned behaviour is an emergent property, a product of interaction; thoughts, emotions and behaviour that cannot be attributed to any one component, but would feed back into the system itself (Kauffman, 1995; Holland, 1995; 1998 Gell-Mann, 1994, Lewin, 1993; McMillan, 2004; 2008; Mitleton-Kelly, 2003a)

The work of Kauffman (1995) is seminal in advancing Darwin's (1859) theory of evolution, where natural selection had been deemed the dominant mechanism for the evolution and adaptation of a species, (Darwin, 1976). Kauffman's assertion that *life exists at the edge of chaos* (1995:71) argues that self-organisation in organisms precedes natural selection and is the necessary precursor for not just emergent order but spontaneous order; "*order for free*" (1995: 71).

It is this notion of spontaneous order that provides a novel complexion to management discourse, as 'order' arises without any necessary hierarchical or

external design, context specific patterns of behaviour emerge and act as simple and local rules that in turn informs system behaviour (Kauffman, 1995; Mitleton-Kelly, 2003a; Stacey and Griffin, 2001; Stacey, 2003a). Goodwin (1997) believes that in biological systems these characteristics have evolved as a means to survival and that living systems are naturally attracted to a ‘far from equilibrium’ position in order to survive; the *self-preservation society*.

Whilst predicating a naturalistic formation of social order, it is a patterning of behaviour that may well account for what some perceive as silo behaviour, where boundaries are formed to reduce outside influence and ensure survival. Noise is a double-edged sword as although (dis)credited with system perturbation, noise and agent diversity are essential prerequisites for the formation of local patterning, and thus the attractor state, around which self-organisation occurs restoring a degree of equilibrium; the system becomes a self-sustaining network of interactions (Kauffman, 1995).

Within this fluid ontology rules are not invariant *a priori* structures, as realist and dichotomous systems would suggest, but patterns that are modified through system feedback. Any notion of identification and modelling such patterns would therefore reflect a structuralist thesis; impoverished science that cannot address the holism of a human social system (Cilliers, 1998);

*“A complex system is not constituted by the sum of its components, but also by the intricate relations between components. In ‘cutting up’ a system the analytical method destroys what it seeks to understand”* (1998:2).

For me it is this alternative perspective of the ability of CAS to spontaneously self-organise into ‘ordered’ and ‘coherent’ patterns when in an energised state that is an essential aspect of complexity that can stimulate management thinking and argues how an organisation can remain ordered but alert and responsive to its environment, able to foster innovative and novel behaviour (Pascale, Milleman and Gioja, 2000).



### **(Re)opening Systems to Co-Evolution – 2001: *A Space Odyssey***

Another essential aspect to accept in living systems is that systems are open and system boundaries cannot obstruct the influences from other systems. Maturana and Varela's (1980) concept of autopoietic systems is restricted as although the authors recognise the capacity of self-reflexivity in living systems, it is thought that the 'strange attractor' triggers an internal dynamic which maintains homeostasis; the system sustains itself without modification (Stacey, 2003a).

The capacity to respond to the environment does represent an alternative ontological perspective, but autopoietic systems suggest the ability of a closed system to live within an open environment, suggesting an identity that is self-determined through internal relations (Stacey, 2003a; Taylor, 2001) This is a limitation for complex human systems that can only explain novelty through natural drift as opposed to the co-evolution of interacting and interdependent systems (Taylor, 2001).

The notion that a system is ontologically stable, closed or reified is opposed by Complex Adaptive Systems theory, which, in complete antithesis, emphasises the connectivity and interdependency of complex systems with other systems in the environment; an open system nested within a larger eco-system (Kauffman, 1995; Mitleton-Kelly 1998, 2003a). Intrinsically system boundaries are transient and porous and the system is continuously subjected to the impact of the many diverse systems operating within the eco-system. The environment of the complex human system is hence reciprocally interactive with that of the outside world and responds and adapts in alignment *with* other systems, they co-evolve (Mitleton-Kelly, 1998; 2003a) rather than co-exist, there is reciprocal transformative change at the interface; a more complex process than reflexive adaptation through a reactive autopoietic response (Maturana and Varela, 1980)

Kauffman (1995) describes co-evolution, where "*adaptation in one organism can alter the fitness and fitness landscape of other organisms*" change is correlative, in some ways unconsciously symbiotic, the micro-level influences macro-systemic change and macro-level influence influences micro-network change, producing what Kauffman describes as a "*co-evolutionary dance*,

*jockeying for places next to one another as mutualists, competitors, predators and prey, hosts and parasites” (Kauffman1995: 215). The outcome is that each system evolves strategies to cope with the perturbations, some of which may be more effective than others, rather than trying to control or prevent the perturbations (Waldrop, 1994).*

### **Understanding Human Systems as a CAS - *Pirates of the Caribbean***

Kauffman’s work provides a persuasive model for our context if we consider that discourses from political, managerial, social and professional domains are continually perturbing equilibrium, jockeying for position. With regard to managerialism, discourse is not necessarily unjust in its objectives, but potentially perilous with regard to their methodology as, in its quest for homogeneity and stability, managerialism is disrupting the rhythm of self-organisation, not allowing new patterns of behaviour to emerge, but prescribing new patterns whilst governance mechanisms and political discourse engender artificial barriers, forcing equilibrium and constraining their ability to co-evolve. As Kauffman (1995) insists co-evolutionary behaviour requires that each ‘entity’ has the ability to influence the landscape of its interrelated neighbours and simultaneously be influenced by them and it is this propensity that emerges as a major failing in public sector managerialism.

Translating the principles of CAS into human social systems provides a valuable adjunct for elaborating on human behaviour, especially where boundaries between social, political, cultural and economic systems are fuzzy (Marion, 1999; Mitleton-Kelly, 1998; 2003a; Taylor, 2001). Gell-Mann (1994) considers the fractal patterning become schemas, ‘compressions’ of information that form dominant patterns of behaviour and activity through feedback mechanisms.

The research of Mitleton-Kelly (1998, 2003a) is prominent in the application of CAS to human system and in its identification of ten major properties. Connectivity, interdependency, feedback and emergence are properties familiar to systems theorists, to which Mitleton-Kelly (2003a) adds, self-organisation, far from equilibrium, the space of possibilities, path dependency, requisite variety

and co-evolution, each informing a Complexity framework with which to alleviate the dilemmas associated with mainstream management discourse.

Although other social frames of reference exist in the field of Complexity I feel I must explain my rejection of Luhmann's model (Stacey, 2003) as it reflects an autopoietic model and also my rejection of the concept of Complex Responsive Processes (Stacey, 2003, Stacey and Griffin, 2006) which although offers a dynamic perspective of the 'system' adheres to realist and structuralist concept of self.

The work of Mitleton-Kelly (2003a) recognises that human systems naturally interconnect without the necessity of external direction and have the capacity to self-organise to create new order through agent interaction and in line with the patterning or 'rules' of the field, but warns that human systems have unique dimensions, the recognition of which advances the principles of CAS engendering a framework that attends to distinct agent characteristics; Complex Evolving Systems (CES)

A crucial distinction emphasised in CES is that human agents have consciousness and memory and are able to reflect on their experiences and learn from them. This means that an agent's choice of action orientates around not only the constraints of the various attractor states with which they interact but also their past experiences and this can strongly influence the activity of an agent and consequently the path along which the system will evolve. Managers who perceive existing and long-standing 'employees' as 'resistant to change highlight the potency of agent experience and historicity' but as fully interactive components, an agent's choice of action will co-evolve, modifying the heterogeneity into a new emergent order. Mitleton-Kelly's work thus offers a profound epistemological statement by incorporating agent reflexivity and subjectivity which in turn engenders an ontology that transcends the realist model of self into one that is fluid, relational and evolving.

### **Complexity in a Business Context – *Mutiny on the Bounty***

The limitations of managerialism is its inability to accommodate the agency, subjectivity, temporality and unpredictability of a CES and by trying to eradicate these perceived faults reinforces the illusion of disorder, chaos and uncertainty (Bauman and May, 2001). Complexity is beginning to emerge as a prime contender in the next era of management thinking, but not as a ‘tool’ of application (Richardson, Cillers, Lissack, 2008). McMillan (2004) considers the Complexity discourse provides a metaphorical ‘gardening-based’ language with which to understand the complex and evolving nature of organisations, but Complexity moves beyond metaphors and can guide the debate towards actually recognising public sector organisations as CES, nestled within the landscape of a larger socio-political system (Lewin and Regine, 1999).

When applied to management discourse, Complexity refuses to see an organisation as stable with change as exceptional and allows managers to ‘manage’ based on that fact (Agar, 2005). Complexity thus deifies the traditional ontological perspective of the organisation as synchronic and bounded, challenging the mechanistic, linear and determinist approaches of managerialism and instead focusing attention on the socio-political perspective, the multi-farious and polyphonic constitution and how agency engenders a self-organising perspective of ‘social order’ wrought through collaborative and competitive inter-relating (Cilliers, 1998; Fonseca, 2002; Greenhalgh, 2000; McMillan, 2004; Mitleton-Kelly, 2003; Streatfield, 2001; Shaw, 2002; Stacey and Griffin, 2006).

Byrne, (1998) contends that the discourses of complexity offer a philosophical framework to fit the *tricky territory* of social systems able to overcome the limitations and generalisations of simplistic and reductionist methods of explication in acknowledging non-linear relationships, multiple and contingent causation and the synergistic aspects of holism. Stacey and Griffin (2006) add that understanding the organisation as patterns of relations requires that dualist models be abandoned as managers, like any other agent, become unable to step outside this interactive process to observe the organisation in an objective

manner. The subjective nature of managers requires they must relinquish control and keep control by not controlling (Streatfield, 2001).

Once this ontological frame of reference is recognized and managers understand the characteristic phenomena of Complexity, CES thinking changes what people see, the innate organisational dynamics and not necessarily what they do and therefore cannot be applied like a novel business process or management fad (Fryer, 2006). Rather than imposing solutions upon employees, CES thinkers allow solutions to emerge, the process of influencing new order is nurtured, rather than being controlled through prescriptive discourses and rigid mechanistic processes that limit an organisations ability to evolve, let alone co-evolve.

Relating this to a commitment-based discourse, Complexity surpasses the notion of ‘teamwork’ as an imposed and artificial concept by acknowledging that interactive pluralism can transcend any notion of orchestrated order (Lewin in Santosus, 1998). The Complexity methodology therefore fulfils an *anti-managerialist* stance (Rowlinson, Toms and Wilson, 2007: 471) and although not necessarily an anti-capitalist stance, it does allow the organisation to respond to the changes in market circumstances in an evolutionary fashion where agents autonomously optimise the use of their knowledge and skills.

As Mitleton-Kelly (2003a) advocates, a CES operating at the far from equilibrium or *edge of chaos* point can adopt several micro-strategies that provide the system with flexibility rather than relying on one single optimum strategy, which may be applied perhaps at the wrong time or may tie up too many resources. The system does not need to remain in perfect order to survive but has to be quicker than its competitors.

A flock of birds is a perfect analogy as each bird acts as a single agent, concerned for its own survival, but together they create a ‘thousand eyes’ all seeing slightly differing landscapes and solutions as they scan for food and danger. This feedback mechanism provides the impetus to act spontaneously which can lead to the phenomenon of *increasing returns* (Arthur, 1990) where

“*positive feedback magnifies the effects of small economic shifts*” (1990:92) which translated to our scenario indicates how early gains allows the ‘flock’ to generate of virtuous cycle of self-reinforcing growth. Grasping this point is essential in an acute health care environment when early clues may stimulate the system agents to recognise aspects of clinical failure, such as increasing infection rates, but of concern is whether this intuitive capacity is being counter-intuitively ‘locked out’ by the (il)logic of clinical devolution, fragmentation and systematisation recognised in the discourses of NHS governance.

There are accumulating examples in the Complexity literature of how principles have been applied, some in more prescriptive ways than others, disturbing the equilibrium, transforming the conditions to stimulate innovation and new order such as participative management and devolved responsibility (Leifer, 1989 Lewin and Regine, 1999; MacIntosh and MacLean, 1999; 2003; McMillan, 2004; Mitleton-Kelly, 1998; 2003a; Pascale, Milleman and Gioja, 2000) The type of inter-relations stimulated however, reflect the crucial point that Lewin and Regine’s (1999) make, that relationships are more than just connecting they must be built on authenticity and mutual respect (1999:10) that the authors suggest must engage the *soul* of the individual (1999:16).

Where principles have been applied it is said that organisational success have ensued that may have not been generated otherwise (Pascale, Milleman and Gioja, 2000; McMillan 2004). Ricardo Semler is a dazzling example of how removing the traditional top-down rule based culture in Semco, successfully released a dynamic, innovative, egalitarian and profitable organisation (McMillan, 2004; 2008; Semler, 2003) and closer to home the success of W.L Gore is attributed to a pluralist and democratic engagement of associates, removing the notion of ‘employee’ and the traditional hierarchical command structure (Gore, 2008; McMillan, 2008) Pascale, Milleman and Gioja (2000) however offer a cautionary tale from Sears, whose Complexity approach ultimately failed due to a continued macro-objective style of management.

The problematic is that rational strategic management has become so entrenched in managerial discourse, letting go and acknowledging uncertainty might seem

misplaced, but when an organisation is in an evolving state, it is not controllable and there can be no inclusive programme, design or blueprint for its strategic management and as such services should be allowed the freedom to evolve in response to their market.

### **Did Gerry have the Right Idea in the NHS? – *Die Another Day***

Where better to start looking at the NHS than through the eyes of ‘business guru’ Gerry Robinson. I am sure any Complexity thinker would recognise how Gerry Robinson’s presence in the NHS in Rotherham General Hospital disturbed the equilibrium, or its *indifference* (Longley, 2008), by loosening the constraints of managerial decision making and allowing the staff and managers to reconnect (BBC, 2007a). Reading the blog page after the transmission, it was fascinating, but not unexpected to note how many respondents had expected Gerry Robinson to come up with the answers. Well, in a subtle way he did, by re-connecting interdependent agents, those with the expertise and experience, who through the alienation of rational NHS reform processes and managerialism had become disparate entities.

Kernick (2002) argues that rational and mechanistic NHS reform processes have little impact on service delivery and that it is time to adopt the *fourth way* (2002: 95) by ontologically re-conceptualising the secondary care organisation as a CAS. This plea is supported by academics in the fields of nursing and medicine who advocate a move from doctrines that attempt to control staff through structural and administrative constraints (Anderson and McDaniel, 2000; Bar-Yam, 2005; 2006; Clancy, 2004; 2005; 2006; 2007; Greenhalgh, 2000; Kernick, 2002; Miller, Crabtree, McDaniel, and Stange, 1998; Smith, 1999a; Paley, 2007; Plsek, P, 2001; Plsek and Greenhalgh, 2001; Plsek and Wilson, 2001; Warfield, 2000; Zimmerman, Lindberg and Plsek, 1998).

However, the methodological strategy underpinning many of their claims is disappointing as they tend towards the psychological need to map or identify attractor states, as leverage points, to engineer organisational outcomes, implying that change can be driven objectively, rather than to stand back and allow health care workers to self-organise and emerge through democratic

engagement. I wholly agree with Anderson and McDaniel's (2000) central argument, that healthcare professionals are *bricoleurs* who each offer valuable and diverse perspectives in the adaptation process, although, I am not sure I concur with their proposed objective exploitation of professional norms, it assumes that temporality, subjectivity and historicity can be disregarded.

With regard to contemporary health care policy, the British Medical Journal (Fraser and Greenhalgh, 2001; Pslek and Greenhalgh, 2001; Plsek and Wilson, 2001; Wilson, Holt and Greenhalgh, 2001) published a series of articles on the application of Complexity in health care, suggesting that Complexity represents *leading edge management thinking* for the newly formed Modernisation Agency, but whilst the language and intent of the Modernisation Agency (NHS Modernisation Agency, 2004) may infer a complexity philosophy their discourse perpetuated a systems thinking paradigm of management underpinned by a rational, linear and glossy strategy.

### **Summary**

Ontologically, the framework of CES abandons the realist dichotomy of the 'system', removing the spatial distinction between system and agents and locating co-evolution and system emergence at the inter-subjective and micro-level. The framework also poses an alternative understanding of social order that can genuinely inform management thinking where 'order' emerges as Weaver (1948) contends as spontaneous 'organisation': a natural phenomenon that cannot be strategically designed and imposed.

The landscape of health care is under great pressure to satiate both political and social demand, but the health care industry is located within a huge socio-political eco-system where unpredictable and multifarious conditions prevail; political reforms, election manifestos, escalating market forces, lifestyle changes, new medical evidence, pharmaceutical marketing and unpredictable diseases, which requires that agents at the front line must be allowed to explore their space of possibilities allowing local and context specific micro-strategies to evolve spontaneously.



The current managerialist approach of systems thinking, with its mechanistic, rational and objective approach places a huge emphasis on planning to ensure standardised outcomes but together with its surveillance culture of performance management and audit is stifling system awareness, closing the thousands of eyes on which the NHS depends to detect the noise, removing the energy on which the system depends upon and preventing them taking control of their own local situations.

The principles of CES thus offer my context a suitable ontological frame of reference that orients around a relativist and de-centred perspective. However, it is an in-depth understanding of agency in a CES that eludes us. Although Mitleton-Kelly's (2003b, 2004a; 2004b) work has a tendency to lean towards an agent-based modelling approach and thus constructivist episteme its true nature is not pursued in depth. Thus I feel it essential to gain a greater understanding of the way in which agency informs the fractal patterning of behaviour and to do this I need to return to the concept of self to understand how the self is constituted in a temporal and relativist human system as portrayed by CES.

### Viewing Complexity through a Post-Structural Lens - *The French Connection*

*“Relativism is not indifference; on the contrary, passionate indifference is necessary for you not to hear the voice that opposes your absolute decrees”*

(Čapek, 1926)

The interactive, reciprocal and subjective nature of agents as represented in a CES and the way this inter-relational activity engenders emergent but unpredictable patterns of behaviour through co-evolution denies the realist macro-perspective of the system and the dualism of self. Mead's (1934) work did lay great significance on the ability of agents to interpret the behaviour of others and reflect on their own behaviour in relation to these significant others, but his thesis founders on the assumption of shared meanings between agents, a concept that this section will explore in greater detail as I re-examine the concept of self from the relativist perspective and how this further informs the understanding of agency in a CES.

By placing Complexity within a post-structural ontology, a novel theoretical framework emerges for this study; an inter-discursive construct that enables me to explore how relativism furthers the shift towards a new way of thinking about agency and order and proposes a powerful and realistic alternative which can radically unsettle the philosophical dominance of rational and scientific models of management.

### **The Affinities of Complexity and Post-Structural Discourse – *A Beautiful Mind***

Although not widely recognised, I am not the first to highlight the affinity between Complexity and the post-structural movement. Although no finite agreement about the post-structural position exists (Dumont Jr, 2008), I consider the post-structuralist perspective as a divergent branch of structuralism, rather than in a position of binary opposition, as moving from the a-structured ontology allows a framework for understanding and accommodating the fractal, arbitrary and non-linear characteristics of the human system. Several authors have contributed to a powerful argument for how the relativism of post-structuralist thinking mirrors the interactive, dynamic and subjective characteristics of complex systems, where notions of order exists, but not in the regular, universal and permanent way of structuralism (Baskin, 2007; Cilliers, 1998, Davis, 2004; Medd 2002, Olssen, 2008; Parellada, 2002; Popolo, 2003; Taylor, 2001). Cilliers' seminal text, *Complexity and Postmodernism* (1998) highlights how the post-structuralist position, as a pluralist concept, mimics the theories of Complexity and stresses how agent subjectivity engenders a system rich in diverse agent interpretation and thus a proliferation of meaning within the system.

As there is a tendency to interpose the term post-structuralist with postmodern, I emphasise at the outset that post-structuralist thinking is a relativist epistemic frame of reference that de-centres the emergence of meaning and the practices of linguistic signification, destabilising structuralist and unified notions of the objective truth and the subject self and rendering any totalising or dominant interpretation as null (Davies, 2004; Kincheloe and McLaren, 2005; Sarup,

1988). On my reading of Cilliers' text and his application of the term *postmodern*, it is clear, especially in his analogy with Derrida's work, that he is taking a post-structural position.

My post-structural orientation gives primacy to several distinct, but convergent perspectives, namely Derrida's (1976) work on linguistics, Foucault's (1972) concepts of discourse and discursive practice and Bourdieu's (1991;1977) concept of *habitus*, offering complimentary theorems with which to gain an in-depth understanding of agency and fractal patterns of behaviour in the CES. As previously vindicated Bourdieu may be thought of as a structuralist thinker, but this label sits inconsistently with his representation of *habitus*, as an experientially generated model that incorporates fractal patterning.

The first similitude is that of emergence, a concept that is not restricted to Complexity, as Nietzsche, (Foucault, 1971) dubbed the 'fore-father' of post-structuralist thought, illustrates a 'Complexity view' of *emergence* as the outcome of the struggle between opposing forces and adverse conditions; "...an extended battle against conditions which are essentially and constantly unfavourable" (Foucault 1971:84). In the attempt to avoid degeneration, Nietzsche's observation reflects how emergence is stimulated in an edge of chaos state, where the tension of adverse conditions stimulates self-organisation.

I also detect how Baudrillard's (1968) thesis on consumerism recognises *indeterminacy*, *fuzzy logic* and *open systems*, again offering a conspicuous resemblance to Complexity, (Lane, 2000: 27-29) but for me it is Foucault's (1972) ontological perception of the social system as circulating systems of discourse that is particularly profound in its resonance with the theories of Complexity. I am surprised that, apart from the recent reflections of Baskin (2007) and Olssen, (2008) who supports the quasi-structuring of discursive systems as fractal patterns, the intellectual conjecture of Foucault has made remarkably little impact on the field of Complexity, each discourse seemingly emerging in parallel.

### **A Critique of Post-structural Critique - *The Man Who Fell to Earth***

One of the central strands of the post-structuralist position is the contention that language is an unstable system of referents, which emphasises the subjective nature of interpretation (Sarup, 1988). Consequently, unlike realism, post-structuralists deem it impossible to capture the actual meaning of a sign; language does not reflect any unified meaning; meaning is a relativist and de-centred concept, full of ambiguity, contiguity and temporality (Neitzche, 1971).

Post-structuralists therefore challenge the realist obedience to the meta-narrative (Derrida, 1976; Sarup, 1988) as a fixed and a priori phenomenon that comprise the realist dimensions of agent functionality, synchronic existence and objective reality. Post-structuralists argue that there is no extra-social access to the world, that all knowledge is socially acquired and thus the prime objective of the post-structuralist position is to re-conceptualise the relationship between agency and agent subjectivity (Craib, 1992; Davis, 2004; Dumont Jr. 2008; Fox, 1997; Richardson and St. Pierre, 2005).

The unfortunate legacy of such raw subjectivity is the promotion of an extremist perspective of society as; *disorganised and fictional* (Rock, 1979); that the world presents us with profound and confusing contradictions implying a schizophrenic diversity of subjective interpretations and impressions and proposing an a-structured ontology of society, without any sense of order; there are no hidden depths, all there is, is what we can see, the surface flux, *chaotic and meaningless* (Deleuze and Guattari, 1977). The radical positioning of such extreme relativism has come under criticism by its opponents (Davis 2004, Habermas, 1987; Norris, 1994; Williams, 1999) perhaps in fear that it would destabilise long standing institutions and destroy a prerogative of some for making political claims (Dumont Jr. 2008) and I must concur at this stage that this nihilistic and chaotic image does not fit the apparent patterned existence of order portrayed by a CES.

Sokal and Bricmont (1997) infamous attack denounces the post-structuralist position as *the emperor's new clothes*, because its assignations could not be tested, or at least tested by their rationalist and scientific methods, but their critique is ultimately criticised for distracting debate away from true intellectual

inquiry (Davis, 2004). It is Habermas' (1987) critique that remains the most prominent in its consideration that the post-structural stance not only undermines the concept of reason and the ethos of Enlightenment (Davis, 2004) it bases its opposing claim using the norms created by modernity. However this modern-non-modern dialectic acutely ignores the central elements of post-structuralist thinking, that norms are based around a unifying meta-narrative and there can be no 'norms' if the notion of the meta-narrative is destroyed (Davis, 2004; Williams, 1999). Norris (1994) asserts that in destroying the notion of agency and conscious engagement, the post-structuralist position destroys any notion of ethical action by agents (Davis, 2004), but of course this makes the assumption that society has created a fixity of discourse with regard to understanding the essence of ethical existence and further assumes that supposedly ethical action engenders well-being for all.

Another vital feature of post-structural thought is an intricate and critical involvement with questions surrounding the relations of power in society (Clegg, 1989; Fletcher, 1999; Mills, 2003; Williams, 1999), that all knowledge is political (Dumont Jr. 2008) and it is this element as a primary endeavour in this thesis that draws me once again to its dysrhythmic heart. Derrida (1967) believes that discursive analysis "*reveal[s] the fault lines of Western thought*" and the "*deeply entrenched habits of thinking*" (Davies, 2004: 2) and exposes the privilege of constructs (Williams, 1999) and places the post-structural in an entirely appropriate position for exploring the discourses of surveillance and control recognised in managerialism.

### **Destroying the Notion of 'I' - *Fight Club***

For me, understanding of the true nature of self and how it informs agency is elusive for Complexity, but the post-structural relativist position does present an attractive conception that eminently fits the CES. If all is relativist then all that exists, exists at the micro-level, at the level of self, which the post-structural position ontologically shifts into the 'interstitial space', the abstract void between 'material' agents, de-centering the self (Davis, 2004). Allen (2000) calls this position an *anti-subjective hypothesis* and claims the *death of the subject* (2000: 114) where the self as an unstable construct, actively and continually (re)constituted through practice (Foucault, 1972; 1979). It is an

unorthodox and novel perspective of self, originally posited by Nietzsche (Robinson, 1999), who contested the realist notion of an independent 'I' and the conscious freedom to choose, arguing that self is a linguistic and cultural construct with no central core of identity as agents are merely the sum of their performances.

The inter-subjective perspective radically differs from Mead's (1934) model and the I/Me ontology of self, employed in the concept of Complex Responsive Processes (Stacey, 2003, Stacey and Griffin, 2006). Mead's model echoes the Lacanian psychoanalytic model of self that whilst acknowledging subjectivity and the uniqueness of self, considers the self is shaped by the dialectic of recognition and constituted by a societal structure (Sarup, 1988). The Lacanian perspective does see the self in tension with a myriad of conflicting discourses and emphasises that images are subjective, unstable and that an interpretation of another's action may be misplaced. However, throughout Lacan cannot relinquish the notion of the free-willed subject and shifts between a rational agentic position and one of deterministic structure, through the notion of reflective objectification of the symbolic other, where the self is immersed within the discourse of the other (Sarup, 1988). Lacan's work also recognises an unconscious dimension to self and his work is landmark in indicating how an individual's identity is an interdependent construct, a cyclical process of interpretation and reflection, where the self is simultaneously fragmented by its subjection to a variety of context specific others (Craib, 1992) transforming the concept of self into a multi-dimensional image of prismatic identities.

Kristeva (Sarup, 1988) develops Lacan's thesis introducing the thought-provoking notions of the *semiotic* and the *symbolic*, which, whether de-centred or otherwise, could exist in some form. Kristeva asserts that the *semiotic* is the 'raw material' of signification, the corporeal, libidinal matter, the natural drive and desires that must be harnessed, or repressed and channelled for social cohesion by symbolic mechanisms superimposed for regulatory control of the semiotic (Sarup, 1988). In relation to the nature-culture debate of agency the semiotic expresses an emotive component of self that may be thought of as a powerful driver in terms of agency. Even if the post-structuralist ontology de-

centres the self, deifying the self into an ethereal state, a continually transforming non-entity in the space between interpretation and practice, the notion of Kristeva's semiotic is profound in recognising the continual struggle of the self under the influence of the symbolic.

### **Habitus as a Fractal Conceptualisation of Self – *An American Werewolf in London***

The ontology of self as deified to any chaotic extreme however is not cohesive with fractal patterning of agent behaviour perceived in a CES; a degree of repetitive or habitual behaviour occurs and even though the patterns evolve. Bourdieu's (1991; 1977) concept of *habitus* thus offers a mid-point on the continuum between fixity and chaos. The concept may appear ostensibly structuralist at its first reading but is a persuasive model apposite for understanding the ontology of self as a complex adaptive system in itself; open to discursive influence but displaying a fractal patterning of behaviour.

The *habitus* is an abstract concept, originally conceived in spiritual terms by Aquinas (Costea, Crump and Amiridis, 2008), but developed by Bourdieu (1991: 1977) into one with material consequences in its ability to unconsciously regulate and inscribe the self in alignment with the normative logic of a particular context (Whitehead, Moodley and Thomas, forthcoming); a somewhat structuralist portrayal of legitimised values and norms that permeate the self, I agree, but Bourdieu (1977) stresses that the rules of the field are only a partial determinant of practice as the *habitus* houses the *hexis* an unconscious intuitive dimension that sits alongside the internalised regularities.

Bourdieu (1977) explains that the *habitus* is a *generative* (1970:78) concept, a product of history that can adapt to demands, but cautions that practice is not necessarily predictive; *habitus* has an “*endless capacity to engender products - thoughts, perceptions, expressions, actions - whose limits are set by historically and socially situated conditions*” (Bourdieu, 1977: 95). This description portrays the *habitus* as a complex adaptive dimension of self, a dynamic concept constituted through experience and education, engendering an intricately infused personal framework of cultural dispositional characteristics, ways of talking and

doing, frequently intuitive or unconsciously delivered, but which reflect the social conditions within which they were acquired and are linked with social positioning and shaped by the pursuit of personal self-interest. It is a concept that reflects an attractor state, but it is clear that agents are not passive and action is improvisatory, like players in a game, and to play the game successfully requires experience and practice (Jenkins 2002; Harker, Mahar and Wilkes, 1990).

Bourdieu's (1991) belief that mankind's sole desire is access to symbolic capital does echo Kristeva's thoughts of semiotic drive, at a more conscious level, where desire will drive the constitution of self and an 'identity' that can maximise return to themselves. It reflects the important and fundamental principle of life that we might again recognise in CAS, self-preservation. The generative and fluid capacity of the habitus is further strengthened if one acknowledges that the *normative logic*, the legitimised norms of the field, is also influenced by interacting discourses, which modify the rules and thus agent practice. Hence, it is important, for those who critique my use of Bourdieu's concept, to perceive the habitus as an open system where the influence of interactive discourses from other fields removes any notion of fixity.

### **The Relativity of Language – *Lost in Translation***

Although Bourdieu's concept of habitus provides an agreeable and fluid representation of self that fits a CES, its epistemic constitution must be examined in more depth especially if we disregard the existence of the meta-narrative. To begin this exploration I return to the post-structuralist preoccupation with meaning, language and subjectivity and the contention that an agent's world is epistemically ordered through the signifying practices of language and symbolic representation.

Lacan (1988) made a significant contribution to the relationship between language and subjectivity through his contention that: *there is no subject independent of language*, the self is constituted through language, asserting that agents do not develop independently but interdependently, in relation with others and it is through this interaction that an agent senses reality (Sarup,



1988). Lacan argues that it is not the literal words but the chains of signifiers behind the words that are important; the symbolic order that becomes inextricably bound to the constitution of self.

Saussure's structuralist thesis on the meaning of signs is innovative in linguistic study and transcends the realist conception of language, as corresponding to objects in the world, by re-focusing on meaning and how words are arbitrary and only acquire meaning through interaction and their relationship with other signs (Nobus, 2003; Howarth, 2000; Sarup, 1993). Signs hence, rather than reflect an objective reality merely represent a concept of reality (Sarup, 1993). For example, the concept of *mother* can only be understood in relation to the concept of *father*, from which it could be differentiated, emphasising a relativist perspective. The unfortunate limitation of Saussure's thesis was in his paradoxical belief that meanings became fixed, that language was self-contained, placing language in a closed system and conferring a 'near equilibrium' on meaning (Williams, 1999). In some ways Saussure's impasse reflects the problematic of complexity and their structuralist, but diachronic dynamic. If everything in the world is in a state of flux how can meaning be fixed (Hospurs, 1997)?

Derrida progresses Saussure's notion of deferred meaning and his re-interpretation is powerful, famously challenging the fixity of meaning, denying the 'metaphysics of presence' and re-emphasising the diachronic and relativist nature of language (Sarup, 1993). Importantly, Derrida's concept of *différance* re-focuses the construction of meaning at the inter-subjective level, at the interface of agent interaction. *Différance* incorporates temporality where nothing is wholly present in one moment; meanings are ceaselessly being re-woven (Dumont Jr. 2008). Translating this to the complex human system it is clear that meanings evolve and are co-constructed between agents, through agent connectivity and feedback. Language is a Complex Adaptive System.

Derrida's work (re)placed language in an open system arguing that there is no outside from where meaning is generated, meaning, like the rules, does not emanate from any one agent, or groups of agents, but exists in the inter-

subjective space wrought through agent practice. Meanings are neither stable nor chaotic and Derrida explains that as soon as a meaning is ‘created’ for a sign it reverberates through the system creating *inexhaustible complexity* (Sarup, 1988: 34) and feedback loops shift the original meaning, even if only imperceptibly (Cilliers, 1998) Therefore meanings slip, but will contain traces of many prior meanings; “*reminders of what has gone before*”(Sarup, 1988:40) which reflects a function of memory and explains how meanings can take on a local and contextualised understanding, or patterning; meaning is fractal, regular yet irregular. In reality, signs do only ever consist of traces (Cilliers, 1998) they are not reified entities at all.

Fox (1997) describes this transformation as inter-textuality, where meanings become distorted as they move between discursive fields, and this explains how the meaning of the term *effectiveness* in the field of health care is transforming through its interaction with the increasing performative influence of political and managerial discourse. Bourdieu (1977) contends that, in terms of meaning, it is the listener that matters rather than the speaker, epistemologically moving the theoretical frame of reference away from an objective position to one of subjectivity.

This linguistic analogy provides a fractal ontology that lies between structuralism’s synchronic structure and the polar nihilistic a-structured vision of a system in chaotic flux and is one that can be synthesised to a CES, like language; there is no stasis, but only traces that constitute system and agent hysteresis. Thus, it is clear why Cilliers (1998), by drawing from Derrida’s work on linguistics shows how post-structural relativism is a suitable ontology for a complex system and how the characteristics of a system emerge as a result of inter-relational difference between meaning and not as a result of the essential characteristics of specific components.

### **Summary**

Cilliers work in particular has endorsed there is more than just a passing resemblance in the discourses of Complexity to the post-structuralist position. Together with Derrida’s portrayal of meaning the post-structural and relativist

frame of reference appears to proficiently accommodate the fractal characteristics of the CES, not fixed, but contextually specific and open to the strange attractors that cross an agents field of play.

Bourdieu's concept of habitus also provides a unique ontology of self as a complex adaptive system, constituted in the interface between interacting agents where agent interaction is unpredictable but tied to both their self and the fractal rules of the field. Habitus, in promoting a self that is constituted by the elements of both slippage and trace progresses a fluid and unpredictable conception of self that surpasses the psychological model of self as a prismatic collection of identities to a seamless notion of 'white light' existing in the interface between agent practice. Interpretation thus becomes a dynamic relationship between agents whose self is caught within several discursive frameworks.

#### The Discursive Constitution of the Complex Evolving System – *Go*

*“There is no truth in the painting of a life, only multiple images and traces of what has been, what could have been and what is now”*

(Denzin, 1989:81)

The work of Foucault expands and progresses Derrida's fractal linguistic ontology to discourse and through his conceptualisation of a human system as a system of circulating discourses each emerging from a multitude of diverse fields. The application of this conception advances my framework for a CES in a unique direction and allows me to epistemologically develop a distinct in-depth understanding of agency in a CES.

The notion that agent practice is influenced by *a priori* discourse is premised in social constructionism, where discourse represents a realist and *a priori* set of social norms whose ideas and beliefs about reality and society underpin and invisibly influence social and political action, actively governing the constitution of self through deterministic socialisation. (Bilton *et al*, 2002) Foucauldian thought however transforms discourse into relativist phenomenon removing any notion of fixity and replacing this with fractal patterning.

### **Understanding the Nature of Discourse - *Patriot Games***

Returning to Foucault's (1972) major analytical thesis, *The Archaeology of Knowledge* Foucault reveals the formation of discourse and the way in which discursive closure and dominance can emerge in a particular context. Foucault defines *discourse* as *statements and utterances, grouped together through regular, often contextual, association, within a social system...*(Foucault, 1972: 80) emphasising how discourse becomes a context specific phenomenon that, like language, is de-centred and constantly being constituted in the interstitial space through agent interaction; "*discourse and system produce each other- and conjointly*" (1972:84).

It is a perspective that contrasts the constructionist theorems where discourse is determined by elitist groups in society (Gramsci, 1971; Reed, 1989; Rose, 1999b) discourses are neither stable, reified nor 'authored' by any one individual or elitist group, but are self-generated through the actions and statements of agents. The constitution of discourse, as in linguistics, is not random, but patterned through the iterative practice of agents as agents interpret and reinforce context specific legitimised behaviour. It is a perception that integrates with Gell-Mann's (1994) notion of dominating schemas, Bourdieu's (1991) concept of normative logic and the fractal pattering of rules recognised in the CES.

For Foucault, "*the atom of discourse*" is the *statement* (1972: 90) and it is evident the 'statement' is more than just a grammatical construction or speech act. Foucault's (1972) lengthy deliberation over its substance broadens the description to encompass anything that precedes and influences the formation of discourse, visual, spoken, written, enacted or even silenced. Like the relativity of language Foucault emphasises the statement has no origins and is not an act of memory. The 'author,' like a cinematic auteur, can, in a pedagogal sense, manipulate and transform, decompose and recompose, knowingly and unknowingly, although no individual, group, whether dominant or suppressed, authors the statement absolutely. Regardless, agents can only interpret statements but never truly know the meaning behind those statements.

However, Foucauldian thinking takes a further twist when Foucault (1972) contends that discourse merely acts as a vehicle for the transfer of statements, verbal and non-verbal, throughout a system and it is the subjective interpretation of these statements by agents and their consequent action that allows ‘discourse’ to naturally evolve and transform. By de-centering the concept of discourse, discourse becomes an abstract phenomenon, which Foucault replaces with the material outcome of co-evolving statements, *discursive practice*; the action that follows interpretation.

Discursive practice exists within the interstitial space between agents and is significant in the way it portrays and modifies the statements of reality. Conceiving discourse in this way clarifies that it is not discourse itself that becomes inscribed on the self as social constructionism would suggest, but that the self is constituted by interactive social practice. The system is re-conceived not as a circulating system of discourses, *per se*, but as a fluid and co-evolving field of discursive practice. Foucault’s ontology furthers the epistemic understanding of self, asserting that the self does not exist prior to discursive practice.

### **Revisiting the Epistemic Constitution of Self through Discourse - *The Bourne Identity***

Foucault, (1988) in his critique of the modernist unification of self, claims that it is the essentially scientific and functional knowledge around which the ‘discourses’ are formulated that aim to categorise and regulate the self. Foucault (1972) asserts that each discursive statement posits a particular concept of reality which, as Lacan (1988) suggests sets up a site of struggle, within the self, caught between the myriad of truth claims posited by other statements, the meaning of which has to be negotiated, fought over and maybe resisted (Clegg, 1989; Dreyfus and Rabinow, 1986). The result is a self that echoes the hexis, a multi-dimensional and fractal state and I interject at this point that Foucault’s perspective transcends the image of self as a site of multifarious identities to an abstraction. This is easily misunderstood in Foucault’s work, where one could get the impression that a discursively constituted self is a determinist phenomenon, the self does not exist, it is simply a field of play where agents

come into existence and present and re-present certain truths about the world (Dent and Whitehead, 2002).

Butler (1990) mirrors Foucault by postulating that agent subjectification is a process of 'becoming' through *performativity*, the allegiance with performative acts that reflect particular truths, agreeing that identity is not inscribed but is discursively constructed, in the inter-subjective space between diverse and competing discursive statements. Butler explains that an agent is unable to consciously modify discourse, because they are unaware that it exists, that agents are just caught up in it. Butler is not implying passivity as although agents may not recognise 'discourse' *per se*, they would be caught in the determining rules that constitute statements and would recognise when these do not align with their hexis. Perhaps it is this misalignment that awakens the consciousness in agents, as Bourdieu (1991) contends that "*some seek[ing] to preserve the status quo, others seek[ing] to change it*" (1991:14). Dreyfus and Rabinow (1986) believe that agents act in a manner that is conscious and volitional, they know what they are doing or attempting to do by their practice, even though they are not aware of the consequences of their action.

The notion of a discursively structured self thus adopts a new complexion in comparison to structured perspectives and is clearly a more intricate phenomenon than role-play. Agents may be quite diverse, even capricious, in what rules they chose to legitimise, system hysteresis and the conscious and unconscious drives of the hexis will play a fundamental role and yet what is difficult to grasp is the degree to which agency drives the constitution of self, can subjects really challenge their own 'subjectification' and modify it through the notion of choice. In retrospect I think the point Butler makes orients around an agent's awareness of the power effects of discursive statements. The discursive perspective does not deny the existence of physical objects but argues that the way we think about their materiality and experience their reality is censured by discourse and the structure it imposes on our thinking (Foucault, 1979)

**Understanding Discursive Practice as a Complex Adaptive System - *Kaleidoscope***  
Like Baskin (2007) I consider that the similitude between Foucault's thought and the principles of Complexity is striking and as a Complexity thinker I reflect how Foucault's (1972) concept of discursive practice is the principal emergent property of the human system, where practice acts as both the attractor and the strange attractor. Foucault (1972) explains that the statements of discursive practice;

*“emerge[s] in its materiality, appears with a status, enters various fields of use, is subjected to transference and modifications, is integrated into operations and strategies in which its identity is maintained or effaced. Thus the statement circulates, is used, disappears, allows or prevents the realisation of desire, serves or resists various interests, participates in challenge and struggle and becomes the themes of appropriation and rivalry” (1972:118).*

Baskin (2007) likens this to the processes of transformation and displacement and considers that discourse reflects the intricate patterns of intention, interaction and unexpected causality characterised by complex systems. Foucault's statement is noteworthy as it not only clarifies how statements circulate through an open system, exposed to slippage and trace, but more importantly how statements can have a strategic function, as conduits of power, by promoting a particular perspective of an object or concept and by defining social relationships and identities within a particular field (Howarth, 2000; Knights and Morgan, 1991).

What is significant in Foucault's work is that he distances himself from raw post-structural criticism by his contention that social systems have an *extra-discursive order* (Craib 1992), a quasi-structured autonomous system of rules and inherent relations of power that at the local level constitute the objects of which they speak, *local narratives* that become legitimised within a field and generate statements of coherence and regular sets of practices (Dreyfus and Rabinow, 1982). Foucault therefore retrieves the post-structural dilemma through a perspective that lies within the continuum between the synchronic structure and the polar nihilistic a-structured vision of social chaos and applies the metaphor *kaleidoscopic* (Craib, 1992) to societal order, in contrast to the

*chaos* and *flux* of Deleuze and Guattari (1977); an apposite term in its implication that fractal patterns arise from the chaos, patterns that can change in response to the power-knowledge dynamic of discursive statements (Sarup, 1988; Dreyfus and Rabinow, 1982).

### **Discursive Practice Creating an Edge of Chaos Ontology- *Sixth Sense***

What is appealing in Foucault's assertions is that they provide an novel frame of reference to fit the CES framework, the complex human social systems as a relativist and reciprocal open system, where diverse concepts of reality exist, meaning is not necessarily given, stable or universal, but fractal order emerges from the chaos through negotiation as agents each legitimise particular ordered perspectives of reality and adapt in response to new knowledge (Baskin, 2007). However if I look beyond Baskin's (2007) work I can reveal that it is not the 'knowledge', as such, but the innate relations of power within the discursive practice of agents that attempts to drive self-organisation and new order in a particular direction.

In this way it may be recognised how diverse micro-concepts of subjective reality are creating the necessary tension for a system to self-organise through negotiation, the necessary competitive-collaborative balance; order emerges in the midst of diverse discursive formulations. Baskin (2007) argues that 'order' exists in a dominant position for as long as the network can sustain that order and explains how new 'knowledge' perturbs discursive closure into a state of phase transition. Hence as agents legitimise or resist the truth claims, which in itself is unpredictable, the CES is placed under constant tension, creating the energy differential that pushes the system into a far from equilibrium position, the point of transformational adaptation.

The fact that discursive statements make *claims to what is valid and invalid knowledge and what can be spoken in a particular place and time* is significant in constituting and defining difference within a particular context. In this way not only do statements attempt to govern they simultaneously engender statements of resistance, modifying the reality that subsequently shapes agent action (Foucault, 1966:1972). This may seem a constraint on agent action, but



what is crucially important for any Complexity thinker to acknowledge is that even agent resistance or inaction engenders system tension and thus the dynamics for change.

What is clearly evident is that the emanating discursive unity of the field, the normative logic, explored in chapter two, is therefore locally formed and contextually legitimised, they are the local rules around which the system self-organises, the normative logic is the attractor state, the comfort zone, towards which each agent gravitates to restore some semblance of equilibrium and as a localised construct they are not necessarily transferable between systems.

Described in this way, the Foucauldian image of discursive order echoes the fractal patterning seen in a CES generating system behaviour that is irregularly ordered, *“fragmented, but orderly at the same time”* (Sanders 1998: 102). Fractal perspectives have an important characteristic; they exist at the interface (Sanders, 1998). Sander’s (1998) comment suggests that by acting at the interface the patterning and emergence becomes located in the interstitial space between system agents, complimenting the relativist epistemology of post-structuralist thought, positioning co-evolutionary transformation at the inter-subjective level. Hence system transformation de-centres the agent, as argued in Complexity, emergent change cannot be attributed to one agent, but is at the interface of all system agents (Mitleton-Kelly, 2003a; Stacey, 2003a).

## Conclusion to the Chapter

This chapter advances management thinking beyond modernist constraints by conceptualising the health care organisation as a dynamic cluster of relations, embedded within a larger human eco-system, progressing the dominant ontological model of the health care organisation as a closed, stable and pre-given system. This re-conceptualisation is one that is valuable to inform the discourse of NHS management; the appreciation of the NHS organisation as a complex open system attempting and needing to interact with their environment, but where politically and managerially boundaries are drawn through policy in an attempt to create stability and predictable outcomes. The Complexity framework of CES therefore provides an alternative understanding of social

order as (self)organisation and how this can be achieved without the ‘command and control’ philosophy of managerialism, but in a way that retains the adaptive, flexible and innovative nature of the human organisation.

Exploring the work of Foucault has been profound in identifying how his conception of social systems through a discursive ontology offers a substantive view of Complex Evolving Systems through a quasi-structural lens, accepting that whilst subjectivity generates diverse concepts of reality, rules emerge as a fractal discursive constructions, creating a negotiated and legitimised order. Discourse thus is not a fixed phenomenon, but continually under the perturbation of agent practice, micro-level legitimisation and resistance that perpetuates the necessary power differential within the system.

Of particular value, merging Foucault’s ideas with Complexity allows me to develop profound insights into the epistemological constitution of the self, its ensuing agency and the socio-political characteristics that influence discursive practice. My proposal that the innate power differentials, manifest by discursive practice, is the ‘noise’ required to stimulate self-organisation and extra-discursive order is both novel and significant for advancing an epistemological understanding of agency in a CES and in doing so provides me with a suitable theoretical frame of reference for this thesis.

This inter-discursive framework elucidates how discursive closure or patterning, although set within contextual bounds is not a fixed phenomenon but always under the challenge of noise as discursive practice, whether this is from political statements or the diversity of agent selves but that regardless it should not be viewed in negative terms but as essential in maintaining system viability, the system has to remain under tension to perpetuate their spontaneous adaptive characteristics. Thus Complexity thinkers must recognise that what is retained in a Foucauldian complex system is the positive effects of *différance*, as defined by clinical, managerial, political and social discourse as this maintains a system of diverse truth claims over which the self will struggle to create meaning, but will maintain the diversity of selves essential to the functioning of a CES and for transformational change.

The existence of diverse and conflicting statements however introduces the critical aspects of power and as I suggest it is this relation of power that prevents the system from stagnating. However, what is recognised in the discourse of managerialism is the way in which a system's naturalistic co-evolutionary characteristics are potentially constrained by a realist philosophy of control and order that marginalises and silences certain statements of health care reality in an attempt to create stability through consensus, homogeneity and uniformity. If expressive relations of power are fundamental to the functioning of a CES then it is essential that I turn my attention to a more detailed exploration of power as exercised through a managerialist discourse.

**Chapter Four**  
**Magical Expressions of Power**  
**- *Monsters Inc.***

## Introducing the Chapter

*“The world is...a repressive labyrinth of social production, a construction of pseudo-selves, who are pushed and pulled by cultural dynamics and subtly diffused regimes of power”*

(Spretnak, 1991: 139)

The conjoined Foucauldian-CES framework developed in the previous chapter presents a novel perspective of agency and social order as discursively constructed. This epistemological portrayal allowed me to explore in more depth how the characteristic phenomena of self-organisation and emergence spontaneously occur as a consequence of discursive practice, but raised the concern that the ability of statements to dominate and distract the definition of health care would risk stifling the naturalistic processes of the CES. To understand this potential effect in more depth, I now turn my attention to the socio-political aspects of discourse to explore how discursive statements exercise control through relations of power. The post-structural perspective contends that the interpretation of worldly experience is inextricably intertwined with the discursive practices that criss-cross the habitus and constitute the self. This view provides the substrate for one of the contentious debates in post-structural circles; the power of discursive claims and their intricate relationship with the world it purports to describe.

Foucault, as one of the most prolific writers on power as constitutive of social discourse is given primacy in this chapter as I consider his work incomparable in clarifying the relationship between power, knowledge and discourse. Foucault’s (1966; 1967; 1977; 1979; 1980a) critiques of modernity and his notion of social control as situated in a concept of power are the most important aspects of his studies and his re-conceptualisation of power engages with three dimensions, the interdependent concept of power/knowledge, the emergence of a modernist ‘self’ through disciplinary technologies and governmentality, (Dean, 1999; Simon, 1995)

These dimensions are situated in the three main phases of Foucault’s work; the *archaeological* phase focusing on the formation of regularity within discourse,

the *genealogical* phase, a diagnostic approach that compliments the descriptive by an exploration of the power/knowledge relationships within discourse and its application on the body through disciplinary practices and the third phase which constructs a non-unified *theory of the self* (Dreyfus and Rabinow 1982). Dreyfus and Rabinow (1982) claim that Foucault's work offers not a theory of power, *per se*, but an analytic of power; as Foucault himself would say of theory; "*One tends to view it (theory) emerging from a given time and place and hence deduce it, to re-constitute it's genesis. But power is an open, more-or -less co-ordinated cluster of relations...*" (Foucault, 1980b). The Foucauldian (1980a) concept of *power/knowledge* thus provides a fascinating insight into the way in which modernist discourses exercise techniques of social control through the exclusion of particular truth claims. With regard to the NHS this allows me to reflect on whether the naturalistic characteristics of the NHS workforce is being influenced by the two major governing discourses that unify knowledge in a modernist direction.

I must confess that embarking on a study of power an unnerving experience and one that should not be undertaken lightly. It is said that power is inherent in every part of society; each limitation introduced, each decision made and any form of inter-relating house inequitable socio-political relations, both real and imagined (Palgrave 2002; Elias, 1998; Scott, 2001; Stacey and Griffin, 2006) and studying the thoughts of philosophers such as, Bourdieu, Gramsci, Marx and Foucault, certainly begins to undermine one's faith in humankind and drastically distorts perspectives of one's own reality and relationships. However, Palys (1993) reassures me that studying Foucault can also energise and liberate through the exposure of the power relations that lie within everyday living.

The nature of power is hard to pin down with conceptualisations differing between a *commodity* (Dahl, 1957), an *energy* (Kanter, 1997) an *effect of dependency* (Elias, 1998) to *discursive practice* itself (Foucault 1980) and it is on the latter micro-perception of power that this chapter will primarily focus. The chapter opens with a brief critique of realist frameworks of power to which structuralist conceptions adhere and provides the basis from which to explore the pervasive use of ideological constructs in management and with which I

compare the exercise of power within the post-structural and relativist system that frames my theoretical thinking.

### **Realist Conceptions of Power- *Animal Farm***

As I revealed in the earlier chapters, the major governing discourses of the NHS appear to be philosophically embedded within a realist ontological conception of the organisation that classically conceptualises power with material and positional dimensions. Power vacillates between two dialectically opposed notions of either a 'common' or a 'pluralist' value system (Clegg, 1989). In organisational systems this begets the dichotomous organisational structure prevalent in secondary care and as a consequence perpetuates the dialectic opposition and the hierarchical relations of power that require and depend upon the legitimisation of such 'inequality' to maintain control and order. The statements of managerialism, however subtly dealt, ultimately polarise relations of power, reinforcing the expectation of leader-follower commitment, ordering the power relationship to permit 'elitist' decision-making and to repress any notion of democratic resistance.

### **Dichotomies of Power - *The King and I***

Polarised models of inequity (Knights and Wilmott, 1999) are innate in the techniques of rational strategic management recognised in the NHS in Wales and it can be recognised how 'state' governance has engendered a shift in the decision making process from the consultant 'elite' (Harrison and Pollitt, 1994) to a political 'elite.' The political 'elite' does not overtly represent the raw Hobbesian (1651) presence of sovereign power; its punitive mechanisms are far less obvious, but may be as effective in dissipating the extent of micro-political resistance and thus subjugating the clinician voice. I cynically suggest the punitive mechanisms are less overt, but they may be as severe if one considers how changes to clinical regulation are beginning to judge the quality of medical practice through a systematic discourse and removing doctors from the register for the failure to follow national guidelines (Baker, 2000).

The binary opposite to 'state' control is the notion of anarchy, a concept that means *without a ruler*, and poses the idea that all forms of state rule are

oppressive and should be abolished (Wolff, 2008) The desire for pluralism is voiced in liberalist theories of power (Dahl, 1958; Mills, 1956; Hunter, 1953) seeking moral and ethical redress for the subjugation of individualism, contending that power should be a possession of the people and that micro-political resistance, that I assume is generated from anarchic individualism can and should be diminished through the democratic process.

This notion of democratic process might in itself reflect the natural human characteristic of self-organisation, which suggests that anarchy may be a short lived phenomenon, eventually forming new patterns of legitimised behaviour, manifest through interactive pluralism. The liberalist notion of power as a possession of the people is in some ways a sound premise, especially with regard to a discursively constituted CES, but what these theories misunderstand is that power is not removed from the people but the capacity to express ‘power’ overtly, as resistance or dissent, has been constrained by the threat of corrective mechanisms. In turn the ability to repress resistance reinforces the existence of authority (Knights and Willmott, 1999).

The archetypal model of democratic consensus in organisations may be illustrated in the notion of *professional bureaucracy* (Mintzberg, 1980), philosophically suited to a human organisation where a consensus is negotiated between the diversity of worldviews. This demonstrates the socio-political imperative of management that must temper leader-follower opposition to achieve a ‘negotiated order’ (Strauss, 1963) although as Richman and Mercer (2004) suggest whether a form of negotiated order has ever truly been achieved in the NHS is debatable. Burton and Higley (1987) consider that ‘elites’ are inevitable in large bureaucratised societies, often represented as leaders of the major organisations, but the authors’ emphasis interdependency in the relationship between the elites and non-elites and contend that there are limits to tolerability. Burton and Higley (1987) describe power, as a commodity, traded within a hierarchal structure, but the trans-active dimensions of power are weakened by Oppenheimer’s (1973) views that in the NHS, bureaucratic doctrines, with their hierarchical command-based structure and rule-based order conflict with the sought-after autonomy of professional members, who prefer to



owe allegiance to their peers and their professions rather than to the organisation (Friedson, 1994).

The genuinely democratic ideal that this pluralist model aspires to accommodate, at least superficially, is where power is held by a number of differentiated groups within the micro-levels of society, organised around their sectional interests, diverse but not divided and echoes the democratic aspirations of the *third way* (Giddens, 1998). The role of the 'managing elite' is to facilitate a compromise of micro-level competition in the bid to sustain organisational order and progress through a notion of 'Habermasian' consensus that paradoxically maintains pluralist interests (Davis 2004). Habermas would not eradicate relations of power, only its misuse and believes that power can be regulated through constitution and institution (Flyvberg, 2001).

Reflecting the *ideal bureaucracy* and *rational legal authority* of Weber (Marsh *et al*, 2000) and the *citizen model* of service in NHS Wales (Beecham, 2006: WAG, 2004) this model of power simultaneously reinforces a hierarchical relationship between the tolerating and tolerated parties (Thomassen, 2006) and a supposedly negotiated and legitimised order where agents accept the unequal distribution of power because they believe that some have the right to give orders (Grey, 2005). Granovetter (1985) furthers that bureaucracy becomes the functional substitute for trust and manifests in manipulation, countering the social inter-relationships on which the concept of trust relies (Friedson, 1994).

As interdependent concepts, legitimacy reinforces the notion of authority as constituted law or consensus cannot legitimise itself (Arendt, 1970). Arendt thus portrays an illusory aspect to power; "*when we say of somebody that he is 'in power', we actually refer to his being empowered by a certain number of people to act in their name...without a people or group there is no power*" (Arendt, 1970:44). Reed (1989) wonders whether the de-skilling process or *proletarianisation* (Child, 1982a; 1982b) is a strategic exercise that makes the technical and socio-political function of management easier; it will certainly manifest in modified patterns of relations. Child (1982b) considers

*proletarianisation* is driven by a governmental preference for the centralised regulation of health care professionals.

Bourdieu's (1991) contends that power revolves around the access to capital and suggests that social capital begets symbolic power; the power delegated to an appropriate representative of the group who becomes the speaker, through the devolved authority to say and do what they do. Bourdieu (1991) believes symbolic capital engenders the force and inertia to hold the dominant/subordinate dichotomy in place and that social mechanisms control entry to the fields, jealously sustaining the gap between politically active and politically passive agents.

Unlike the sovereign forms of power, the pluralist model does not overtly prohibit the mobility of agents into the higher echelons of the organisation and competition is encouraged through equal opportunity policies (Knights and Willmott, 1999). The authors add that agents are expected to compete on a meritocratic basis, but ironically when they do not succeed agents are invited to blame themselves for their own failure and inadequacy simultaneously reinforcing difference and legitimising the dichotomy of a power relations within the hierarchy (Reed, 1989). Savage (1998) considers this is how the phenomenon of the *career* emerged, the by-product of pluralist models of power and thought of as the means to secure cohesive order in large complex organisations, but what these models of power actually acknowledge is the polyphonic temperament of the organisation and the face of organisational disequilibrium, uncertainty and agency, but rather than accept them it treats them as dysfunctional (Reed, 1989)

### **Discursive Power: Ideological Notions of Control - *My Fair Lady***

The Frankfurt School of Critical theory and the work of Adorno, Habermas Horkheimer, Marcuse and Althusser introduced a radical perspective of power as a macro-discursive construct, furthering the thoughts of Marx, and replacing the materialist ontology of power with the notion of ideology (Craib, 1992). Theorists contend that ideology is not politically neutral and acts strategically to organise and exploit agents by reproducing relations of power through a

discourse that orientates around an underlying privilege, creating and maintaining a society that ‘tolerates’ exploitation, oppression and alienation (Althusser, 1984; Craib, 1992).

In support of Arendt’s (1970) comments, Althusser (1984) agrees that ideology can only function if it is legitimised by those it intends to exploit by making ‘imagined’ relations of power seem natural and rational. Broadening Marx’s economic perspective Foucault (1980a: Ch4) contends that ideology always refers to a particular order which stands in a secondary position to a particular infrastructure, positioning truth claims as dominant and creating a centralised and bordered premise that would exclude or invalidate competing claims to the truth. Nietzsche (1910) asserts that ideology seeks to generate a fixed meaning and order; truth is simply the illusion of particular norms and values and consequently truth claims are not transcendental entities but instrumentally created (Robinson, 1999).

Ideology is a persuasive concept that presents with a social constructionist framework for understanding the relational nature of power, a relationship grounded in the dimensions of co-operation, but a relationship where the privileged and inequitable effects of power are obscured to maintain the status quo (Bourdieu, 2001; Reed, 1989). There are numerous definitions of ideology but Rose (1999b) encapsulates the point that knowledge functions to achieve social legitimisation; *“resources in the services of power, driven and shaped by political and professional interests, serving to legitimate and mask the manipulation of human beings for the ends of social order and private profit* (1999b: xiii).

The normalising mechanism of control in ideology *welds* (Williams, 1999) or *moulds* (Gabriel, 1999) the self, constituting individuals as subjects (Clegg, 1989; 1998, Gramsci 1971; Marcuse, 1964). An agent is not just exposed to discourse, but is inter-subjectively constituted by its claims; *“[Ideology] constitutes the social actors organisational consciousness”* (Mumby, 1988: 157). Depicting its subtle nature, Stacey (2003b) says of ideology that it acts as a *silent conversation*; *“it preserves the current order by making that current*

*order seem natural*” (2003b: 125) and is profoundly disturbing in the way it can influence and reorder the hierarchy of values within an agent’s self (Bauman and May, 2001). Przeworski (1980) emphasises however, that “*if an ideology is to orient people in their daily lives it must express their interests and desires*” (Przeworski 1980: 21) and supports Bourdieu (1991) contention that an agent’s practice is intertwined with their dispositional hexis and they act to satisfy goals that they believe are worthwhile. Mirroring Bourdieu’s dispositional constitution of the hexis, Gabriel (1999) explains that socialisation goes beyond conscious internalisation to an absorption of norms into an agent’s emotional and symbolic life to an extent that it determines their self-directing potential.

If as Wilmott (1987) suggests, the function of management is to sustain the hierarchy of power relations then ideological mechanisms of control do propose an ingenious mechanism to achieve control relative to punitive mechanisms; the aspiration of ideology is the generation of commitment (Clegg, 1989). Douglas (1986) contends that the prime aim of this *invisible* mechanism of power is to homogenise values and instil an *a priori* agenda. Hunter’s (1953: 246) suggestion that “*the process of manipulation becomes fixed...the ordinary individual in the community is willing that the process continues...obedience of the people to the decisions of power becomes habitual*” (1953: 246) is a compelling but distasteful thought. Zizek (1999) introduces another significant but menacing component to the mechanisms of ideology, where appealing to an agent’s desire is but one side of the coin, as any mechanisms of control rather merely shaping desire is also appealing to agent anxiety, the concern over failure and the need to dissipate this anxiety through conformance (Wright and Wright, 1999).

Hence ideology exercises *hegemonic* (Gramsci, 1971) control, mediated through a discourse that proclaims rational and moral norms for appropriate behaviour and expects this to be legitimised through the reasoned and logical consent of agents; “*they systematically direct individual memory and channel our perceptions into forms compatible with the relations they authorise. They fix processes that are essentially dynamic, they hide their influence and they rouse our emotions to a standardised pitch on standardised issues*” (Douglas 1986:

92), but what is also legitimised is a fixed differential of power, an acceptance of order that generates passivity; the *supreme* exercise of power (Lukes, 2005), but is one that portends death to the CES.

Habermas (1976; 1990) attempts to rescue the overriding negative connotation of ideology, believing that imposing societal normality is both desirable and attainable as a means to compose the necessary bedrock for an emancipated and progressive society. Habermas (1990) contends that *communicative rationality* is a significant element of the reasoning process in pluralist groups achieving democratic consensus through participative dialogue; every agent affected by a norm would have an equal say and could equally exercise their rights and hence truth and justice would be determined through rational process and the rationality of an instrumental means-end relationship (Habermas, 1990; Hirschkop and Shepherd, 2001; Thomassen, 2006) although Bakhtin (1970) argues that the sole impediment of ideology is that dialogue is not unfettered.

Although it may be considered that Habermas complements the Foucauldian view of a reciprocal and discursively constituted society, this is his only commonality, as the Habermas (1994) is essentially romantic in the belief that communicative action is neutral and orientated towards mutual understanding and makes a huge assumption that consensus is ever mutual or rational. Habermas' (1994) argument is based around a principle of legitimisation of the norms, contending that as "*the addressees of the laws are able to understand themselves as simultaneously the authors of the laws, they will be able to relate to them both strategically but also out of respect* (Thomassen, 2006:4)

Gramsci (1971) believes the societal '*intelligensia*' play a role in dominating the philosophical basis of ideology and describes how hegemonic power flows from dominating intellectual and moral leaders who dictate and enforce particular norms, a mechanism recognised by Foucault (1973) where the medical profession, deemed as well respected *pillars of society*, were recruited to promote idealistic messages on societal behaviour.

Agency revolves around the capacity for choice, and in an ideological exercise of power choice is indeed available, but is not always the product of conscious decision-making as ideology manipulates choice, obscuring an agent's 'freedom' to choose; choice and consequent action becomes subject to constraints manufactured by others (Bauman and May, 2001). Bauman and May (2001) express the sinister overtones of ideological power where agents are responsible for their own actions and where, ironically, failure to make the right choice can still result in punishment.

### **Ideology in Organisational Management – *La Dolce Vita***

Ideology clearly perceives the organisation in polyphonic terms (Clegg, Kornberger and Carter, 2003) recognising its heterogeneity and the dimension of agency. The ideological component of managerialism thus attempts to shape agency through truth claims that are not based on consensus, but are distorted to privilege 'managers' interests (Mumby, 1988; Thomas, 2007). The discourse of 'culture' and commitment hence became a significant aspect of managerialism founded on the belief that 'culture' could be managed to engineer competitive advantage (Costea, Crump and Amiridis, 2008; Smircich, 1983) engineering a homogenous organisational culture by shaping an agent's perspectives of organisational reality (Wilmott, 1993). The notion of shared values and a shared social unity aimed to manipulate the 'gremlin' in the organisational machine (Costea, Crump and Amiridis, 2008; Pascale and Athos, 1982), where the shared values that emerge are hierarchically defined and directed towards productivity and profitability (Grey, 2005).

Akella (2003) reveals an ideological premise in the *Learning Organisation* (Senge, 1990) where statements ordinate a family approach, collaborative ideals, participative decision making with the aim of generating organisational commitment, by blurring the work and home boundaries; *the employee becomes emotionally blackmailed* (Akella, 2003: 52). As Smircich (1983) contends and our CES would suggest, culture, even if a unified picture could be observed, is spontaneous and unmanaged emergent phenomenon and certainly will likely as not conform to management thinking.

To bolster this superficial appreciation of the agent, discourses that attend to the *governance of wellness, happiness and self-actualisation* surfaced (Costea, Crump and Amiridis, 2008; McGillivray, 2005); discourses that certainly seem to drive into the ‘soul’ of the agent through the more spiritual concepts of health at work and the work-life balance (Costea, Crump and Amiridis; 2008). The authors contend that in practice the wellness agenda is formulated through the appropriation of the ‘Human Resource’ discourses that attend to absenteeism, health and safety, incapacity and stress. Stress, however is an interesting factor as ideological mechanisms of control as discourses of commitment generate a work climate where failure is deemed personally unacceptable (Streatfield, 2001) but where any notion of resistance is silenced (Sarra, 2006). Reflecting on Zizek’s notion of anxiety, ideological approaches generate agents who will simply conform to reduce the impact of anxiety and stress and this will ultimately impact on any risk-taking activity and experimentation.

Another complimentary strand of ideological control is the idea of capturing and sharing knowledge as *the platform of personal and collective success* (Costea, Crump and Amiridis, 2008: 669). The capturing and sharing of knowledge is well established in management discourse (see Blackler, 2004). Drucker (1954; 1992) has dedicated his life’s work to nurturing the concept of *knowledge work* and *knowledge workers* and is recognised in the concept of the Learning Organisation (Senge, 1990). However, discourse makes the assumption that agents willingly see themselves as *participating in a continuous process of knowledge creation* (Costea, Crump and Amiridis; 2008: 669) through the processes of actively sharing personal knowledge and making the tacit more visible or explicit (Costea, Crump and Amiridis; 2008).

### **The Limitations of Ideology - *Brave New World***

Whilst ideological theses do offer a valuable understanding of the covert and manipulative power of discursive statements, ideological models supposedly reflect the wishes of the dominant groups that construct them and thus assume the notion of consensus within this ‘dominant group’, but essentially any consensus cannot exist external to this group (Abercrombie et al 1980; Dean 1999, Lukes, 2005). The presupposition stands that an agent’s interests and

desires can be recognised by those formulating the discourse, a process, which of course, can only ever be subjectively realised, and assumes that once recognised these interests and desires will remain stable.

The most acute limitation is grounded in the dichotomous ontology and structuralist presumption that socialisation is a one-way irreversible process and the question this raises is whether agents are consciously aware of ideological constructions. Butler (1990) argues that an agent is unable to modify the discourse, because they are unaware that it exists, that agents are just caught up in it, but Žižek (Wright and Wright, 1999) suggests otherwise, that although agents are caught up in the construct and tend to go with the flow, that ideology does not necessarily delude an agent's conscious and reflective ability suggesting that agents are frequently aware of the constructed nature of 'reality'.

Scott (2001) perceives the notion of hegemonic compliance as a superficial cloak of deceit, arguing that compliance is misread; power is a reciprocal relationship between two agents and agents constantly, but covertly, rebel. What Scott (2001) is recognising is agent (in)action as a source of micro-level power; the power of agency. It recognises that power does not simply emanate from *above* but operates *within* a social body (Foucault, 1980a). Agents, whether dominant or marginalized, are not in dichotomous isolation and ideological constructs cannot simply operate passively in one direction (Scott, 2001). The self retains its capacity for conscious intent and its unconscious desires, therefore agents are never powerless but have the capacity to articulate their own interests or resist in some fashion (Clegg, 1989; Foucault, 1984b).

Nietzsche (1910) contends that an agent's interpretation of the world is determined by their self-interests and maintains that their "*Will to Power would determine [their] Will to Truth*" (Robinson 1999: 59) which means that an agent is able to exclude claims to knowledge that do not align with such desires and self-interests. Consequently the predicament of ideological mechanisms of power is in their naive assumption that agents are not active in shaping their own self and that agents will not choose an alternative course of action, even if this does attract a punitive response.



### **Summary**

Whilst realist and ideological perceptions of power offer persuasive aspects to an analytic of power in managerialist discourse the epistemological reasoning does not correlate with self-organisation as a spontaneous activity within a CES; discourse is demonstrated in the previous chapter as a co-evolving phenomenon and thus its power effects must have some reciprocal qualities. However, Arendt's (1970) contemplative comment that authority in any system requires the need for legitimacy, that authority cannot legitimise itself is fascinating and implies that agents do have the power of resistance and Scott's thoughts (2001) compliment Arendt's view.

The thought that agents legitimise some rules and pay scant regard to others makes me reflect on the illusory and imaginative aspects of power. Do we all believe that someone has control over us, controlling a resource that we desire or do we go, as Butler (1990) suggests, with the flow. Are we exploited, is control truly there, in others, or is it because the self constitutes a hegemonic expectation of its presence; norms condition the self to accept the authority of hierarchical control and we expect to be punished if we contravene those norms; if we accept the punishment their power is weakened. Does power have magical qualities, the ability to manipulate our imagination and conjure up a reality of authorised control? Undoubtedly, but how does it achieve this mysterious capacity.

### **An Exploration of the Power Effects of Language – *Look Who's Talking Now***

Even though the conception of ideology is limited and rejected in this thesis because of its assumptions regarding the passivity of agents and its ability to stand as an *a priori* entity, statements of discourse do attempt to order knowledge and act strategically within a discursively constructed social body. The legitimisation of knowledge is intricately enmeshed in an agent's perception of reality and the politics of language in conveying that reality, influencing and reordering the hierarchy of values in an agent's self. Foucault (1976) argues that in any social field *manifold relations of power [which] permeate, characterise*

*and constitute the social body* (Foucault, 1980a: 93) and explains how in modernism the *political status of science was the ideological function that it could serve* (Foucault, 1980a: 109).

It is language that allows power to circulate throughout a network and this next section returns to a relativist ontology to elaborate on how power is exercised through language and elaborates on why language is not a neutral tool in the communicative process (Thomassen, 2006). This section also revisits the Derridean concept of *différance* in more depth to reveal the power effects of binary opposition and exclusion (Derrida, 1976) and how discursive knowledge can be reinforced by the legitimised authority of the speaker and reified in the construction of texts.

### **Language as the Strategic Exercise of Power-*The Mission***

Neitzsche (1971) argues that meanings are never absolute, but full of ambiguity, contiguity and temporality (Foucault, 1971) and claims that humankind is trapped in language, that there is no knowledge beyond language (Williams, 1999). Wittgenstein claims that we are all bewitched by language, assuming words have a metaphysical component, an *a priori* meaning (Parker, 2004). In many cases this is an accepted practice; the human tendency for ordering means that language has become a suitable media by which to categorise; a means of coping with the complexity of the world and agents are endlessly ordering and re-ordering reality, but some meanings have consequences that echo across space and time (Parker, 2002). It may be obvious when someone is talking about a table or a chair, but what if someone is talking about 'organisational identity' or 'culture'?

Language is significant in the way it can legitimise and advance selective accounts of reality (Hastings, 1998) constraining alternative conceptions. Gee (1999) contends that language acts as a *scaffold for social activities and human affiliations* (1999:1) and thus it becomes difficult or impossible to think or express oneself outside of these constraints (Mills, 2003; Williams, 1999). Foucault (1999) refers to a *suspicion of language* arguing that language *does not say exactly what it says* (Williams, 1999:77). Williams (1999) explains the

power of language lies in the way it can eliminate the distinction between thought and language, an aspect revealed in my exploration of the context; language does not represent thought but generates concepts directly; *more depends on what things are called than what they are...we cease to think when we refuse to do so outside the constraints of language; we rarely reach the doubt that sees this limitation* (Lawson, 1985: 44-45).

Derrida's (1967) thesis on linguistics illuminates how language does not only create truth claims and privileged images of reality, but orders and differentiates amongst agents in society. Derrida's concern is elucidated by the concept of *différance*, which highlights how the signs can create difference by including some images but by excluding others (Sarup, 1988). Derrida's critical position explains how deferral can engender relations of power and how a privileged meaning is constructed through absence. This quote by Sarup (1988) clarifies Derrida's thinking; "*He sees the sign as a structure of difference: half of it is always 'not there' and the other half is not that*" (1988:33).

Derrida argues that ordered metaphors and signs are woven into everyday speech setting up binary opposition, ways of seeing the world where one sign is privileged over another implying an order through a hierarchy of meaning that promotes a sharp distinction between conceptual opposites through ordinate and subordinated terms, work/leisure, rationality/emotion, strong/weak, male/female, truth/falsity (Sarup, 1988). Sarup's (1988) interpretation of the Hegelian story of the master and slave, although irretrievably structuralist, does portray how a human subject comes to recognise themselves in relation to another and how that identity would be lost without such differentiation.

Another example of binary opposition is how work has become the dominant term in modern society; *weekends are breaks between work* (Sarup, 1988: 48). Work is associated with importance, leisure as frivolous and in this way the use of one sign over another can insidiously shape agent judgement and action (Sarup, 1988). Derrida's classic example is the term *pharmakon*, a Greek word that represents both cure and poison. It is a case of where you draw the line,

which may be simple in terms of male and female, but less so in terms of when how one decides to judge and define rationality and emotion.

Boje (2001a) explains how every statement or story strategically legitimates a centred point of view, an 'ideology' among alternatives and it is through our interpretation of the language of statements and stories that we constitute our sense of self as distinct subjects, within the myriad of discursive practices (Clegg, 1998). Clegg (1998) emphasises that the constitution of self is not fixed but is *a site of constant struggle where meanings are posited, resisted and fought over* (1998: 29) although Derrida (1976) explains that the ordering of language becomes blended seamlessly in every day speech, but the process of deconstruction can unmask the authoritative claim (Boje, 2001a). Boje, however, is quick to remind us of the relativity of any statement or claim as their circulation within the social body constantly modifies them through subjective interpretation and practice; the centres of authority warp as knowledge is added, reinforced or resisted.

In terms of understanding the effect of language on agency, innate in Derrida's concept of *différance* is a more powerful undercurrent, not merely an ordering of signs, but the subsequent capacity to legitimise this ordination and defer naturalistic agentic characteristics. Language invokes a relationship and agents actively constitute that relationship through discursive practice (Fletcher, 1999). Ishiguro's novel, *The Remains of the Day* (2005) highlights how a 'professional work ethic' can lead to the genuine deferral of emotional characteristics and reflects Luke's (2005) comment that the real interests of those who are subjugated become distorted and obscured through normalising processes that forces agents to be preoccupied with something else (Knights and Wilmott, 1999).

However, is the ordering of language adequate enough to achieve its desired objectives, especially with regard to the dilemma of subjective interpretation? Bourdieu (1991, 1977) adds that language is tied to the habitus, affording an agent with a sense of how to act and respond; a sense of what is appropriate. Bourdieu (1991; 1977) considers language is a competency and capital, a prized

resource, in terms of power and authority, and this notion is recognised in medicine with their convoluted and specialist terminology. What is significant is how the dominating language can engender *symbolic violence*; the language equates with speaker distinction and act as signs of authority, intended to be believed and obeyed (Jaworski and Coupland, 1999); a phenomenon that might be reflective of the continued doctor-nurse subjugation and the perpetuation clinical-managerial conflict.

### **The Power of the Speaker -*The Great Dictator***

Aristotle's (1991) narrative on persuasion accentuates the importance of the speaker in generating legitimisation for discursive claims although Bourdieu (1991) argues that legitimisation is a more complex phenomenon incorporating other social and cultural mechanisms. Bourdieu (1991: 1970) describes *linguistic habitus* as the cultural propensity to be able to say certain things and express oneself in certain contexts, by virtue of competence, status and importantly the access to the social space in which to apply this ability and this aspect of power can certainly be recognised in both political and medical fields of health care. With regard to this thesis, the question in health care is, who is speaking with authority and who is expected to listen?

Bourdieu (1991) believes that social and cultural mechanisms control entry to the field, jealously guarding the gap between politically active and politically passive agents. Godwin and Harness-Goodwin's (1997) analysis of the way the police were cleared of the Rodney King beatings demonstrates this concept; that the status of the police gave them the power to speak as a 'professional,' assumedly qualified to speak the truth, diminishing the validity of an 'ethnic' voice. This exclusion principle is recognised in Marx's (1844) *theory of alienation* (Craib, 1992) and later developed in Lukes' (2005) radical view of power. In the NHS this may reflect the way politics now dominates the decision making process, excluding or limiting the clinician's voice, where NHS managers add a 'glass ceiling' of constraint between the two.

Bourdieu (1991) elaborates how the use of a correct, legitimate and accepted language is able to exert control of the dominant discourse, maybe through

coercion or constraint, and can become tools of intimidation and abuse. In allegiance with Bourdieu's view, Foucault (1980a) describes the *rarefaction of the speaking subject* where a speaker must make a claim to authority to be able to speak about a subject; *medical statements cannot come from anybody...they cannot be dissociated from statutorily defined persons* (Foucault, 1972: 56) and explains how statutory rights involve a complex mix of competence and knowledge, institutions, pedagogical norms, legal conditions and differential relations in respect of society as a whole (Foucault 1972).

Consequently the statements of discourse are validated if they are attributed to someone in a position of authority. Gramsci (1971) talks of the power of the 'intelligentsia' (Craib, 1992) and Foucault (1972) explains how the extension of technico-scientific structures into particular domains provided the intellectual with credibility, authority and thus strategic power. Foucault (1972) applies the term *authorities of delimitation* to describe agents who can exert control over discursive formation, seeking closure, by determining the (in)validity of knowledge.

Bourdieu (1991) adds that the speaker's anticipation of how their 'narrative' will be received determines what they say and how they say it, but contends that this self-censorship becomes a self-determining factor that re-generates their social position; if they feel subordinated their feeble action reinforces this; the weak are defined as the weak (Foucault, 1980a). Agar (2005) considers that the worst parody of the 'command and control' structure is where one does not speak unless spoken to and then only to agree. The aspect of social status may be apparent in our context as it adds to our understanding of the continued subordination of nurses in relation to medicine; exclusion is exercised by giving authority to the doctors which in turn reinforces the notion of difference and their position in the health care hierarchy and dramatically affects not only their action but their ability to acquire, resist or employ relations of power.

The function of rhetoric is an important dimension of speech, claimed as; "*the art of using language effectively*" (Brooks and Warren, 1979: 5) and is more powerful than mere grammatical competence as it performs a strategic function

(Brooks and Warren, 1979; Lyne; 2001), a “*conscious and purposive symbolic action*” (Foss, 1991:16). Rhetoric is not transparent, but has epistemic foundations that exhibit an underlying motive, “*the use of words by human agents to form attitudes or to induce actions in other human agents*” (Burke, 1961:41). Rhetoric is instrumental, persuasive, manipulative and contrived in its power to emphasise a legitimate view of reality, to change opinions and attitudes and hence to influence action (Brooks and Warren, 1979; Burke, 1969; Hewison, 1997; Simon, 2000).

Aristotle (1991) describes three dimensions to the art of persuasion, the character and credibility of the persuader, the ability to stir emotions of those he aims to persuade and the proof of truth, or apparent truth. It is therefore a conscious activity on which Black (1997) reflects; “*if rhetorical activity were instinctive, spontaneous, uncrafted and uncontrived then the discipline of rhetoric would lose whatever identity it had sustained for two thousand years*” (Enos and Erlbaum, 1997: 23-24).

Lyne (2001) maintains that rhetoric acts as a trajectory for discourses yet disorganised, devising lines of ‘argument’ to enmesh a new discourse in alignment with other social norms. Hastings (1998) contends that rhetoric aims to proffer Logos, a rational argument, Ethos, a moral stance and Pathos, an emotional response in its audience. Hamilton’s (2004) paper on the articulation of rhetorical devices in NHS policy concludes it can be a persuasive and appealing tool to substantiate logical and moral arguments and emotional responses by generating an identity with its audience. Reflecting on the political discourse in Wales (Beecham, 2006; WAG, 2004; 2007a,) the political emphasis on service inequity drives the emotional dimension, appealing to public intervention and the notion of a *citizen-led* service to tick the boxes of ‘logic’ and ‘morality’, but in real terms policy documents say little about how the citizen voice at any level will access to the political space.

### **Consolidating Truth as Text – *The Greatest Story Ever Told***

As my earlier exploration of the discursive constructs of political governance asserted, one must always question the document (Foucault, 1972). Who was the

author, why was it written and what its expressive value is. What does it say and what does it not say. Do statements make misleading claims by privileging certain values at the time of their construction? Foucault (1972) asserts that historical documents determine our understanding of the past by valorising certain events, but ignoring the micro-events, the breaches and dislocations, making the visible invisible by silencing voices. Foucault contends that what is written and disseminated demands attention is given to this knowledge (Foucault, 1976).

Derrida (1998) argues that power is attributed to those who have the authority to write on a particular subject; “*writing can ally itself to power, can prolong it by implementing it, or can serve it...*” (Derrida, 1998: 50) and extends the power effects of language through concrete artefacts, where the written form can easily be conceived as the truth. A hypothesis or proposition may be written as just that, but can be misread and repeated as a statement of truth; even without any evidence to substantiate its existence. In real terms writing can support and solidify the abstract and conceptual but silence through omission (Foucault, 1972). Foucault (1976) considers that writing can subjugate and disqualify knowledge as inadequate or *naïve* or in its resistance to the strategic agenda. Ehrensals (2001) recognised this power effect in education, where political discourse defines the problems of drugs and violence in schools in ways that excludes certain voices and interruptions producing a discourse that limits not only the schools perceptions of ‘children’ but also their strategic direction.

However Foucault (1980a: Ch11) impresses upon us that the power of text is in its ability to create a corpora of documents that appear homogenous and cohesive and reinforce common message. Fox (1997) uses the term *intertextuality*, where the messages of one text become seamlessly integrated within another; one text plays upon another. Returning to my exploration of the context demonstrates how the balance of governance has shifted towards prescriptive policies where politicians act as authorities of delimitation in their control of the health care space. It is evident that policy documents reinforce this position by constituting and ordering the functions and regulation of health care and its evolution within a specific framework that prescribes a scientific discourse of



uniformity, performativity and regulation; throughput dominates over clinical outcomes, prevention over cure, home care over hospital care, systematisation over individualisation and productivity over research and its rhetoric persuades us that this is what the populace want. The discourses of clinical governance, although emerging from an assumedly apolitical direction are outwardly silencing the macro-quantitative dimension of political discourse and re-establishing the qualitative aspects that appeals to clinicians, but in effect, clinical governance is adding to the corpora of political documents that reinforce the same values and engender a new perspective around which the achievements of medicine can be judged.

### **The Language of Managerialism - *Doctor in Distress***

I previously ascertained that managerialism is an intricate and multi-faceted philosophy that privileges the discourses of rational management and exercises a scientific and ideological mechanism of control over agency. In the secondary care sector, managerialism is re-defining the concept of effectiveness in a way that appears both logical and natural to the agent but is colonising and normalising clinical discourse with a vocabulary that mirrors the language of commerce, performativity and commitment (Brooks and McDonald, 2000; Costea, Crump and Amiridis, 2008; Gilbert, 2005; Learmonth, 2005).

The language of commerce has turned patients into clients, customers or service users. Whilst I do not myself concur with the notion of labelling somebody with a medical condition a *patient* I do wonder if this contractual terminology is attempting to remove the anxiety and emotion that accompanies that condition, simplifying the complexity of the 'patient' self to fit the increasingly scientific approach of operational management. The consequential inter-textual managerial and clinical discourse will therefore modify the discursive mix of principles, re-constituting the clinician habitus and the way they play the game.

The language of performativity is also recognised in the term performance management, a term that establishes a link between personal engagement in the work process with an increase in productivity (Costea, Crump and Amiridis, 2008). The commitment-based philosophy consolidates this discourse using

language to imply a unified ‘identity’ that incorporates the notion of professionalism, where the self legitimises the ‘shared values’ of scientific and evidence-based practice, but in a way that would foster innovation and service reconfiguration and the capture of tacit knowledge, through concepts, such as empowerment, participation, shared values and self-managed or cross-functional teams (Costea, Crump and Amiridis, 2008).

Ripley and Ripley (1992) consider that empowerment acknowledges the talent and creativity of individual employees, but Foucault (1986; 1988) argues that empowerment is a means of reducing resistance by driving into the very soul of an agent; shaping an employee’s self through mechanisms of self-regulation and autonomy, rather than through discipline and and constraint. Foucaults (1986; 1988) concept of *technologies of self* might be a suitable metaphor to reflect a rather manipulative measure that;

*“Permit individuals to effect their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct and ways of being, so as to transform themselves in order to attain a state of happiness, purity, wisdom, perfection or immortality”* (Foucault, 1988a: 18).

The ‘mission statement’ further upholds the notion of organisational unity, a statement that epitomises an ideology aimed at generating workforce commitment through a common organisational ethic, a *false consciousness* (Parker, 2002). Parker considers the mission statement as a means of internalised coercion that speaks on behalf of the workforce by using the terms *us* and *we*. Lyotard’s (1988) analysis of republican power in France in *The Differend: Phrases in Dispute* recognises how the term *we* has a capacity to harmonise discursive norms. Lyotard (1988) inquires of the identity of the *we*, whether this is the *we* that constitute the norms or the *we* who are obligated to them and argues that the two do not completely overlap, but suggests that the notion of this collective identity obfuscates and confuses the political asymmetry, disguising the difference, by making it invisible *by reducing it to bland commensurability* (Benhabib, 2006; 133) and renders the incongruent and unfamiliar homogeneous. Benhabib (2006), however, wonders in the fragility of

our postmodern world if the ability to shape any notion of collective identity is becoming less and less likely.

Regardless of this futility, the objective of the mission statement is to persuade agents that managers are acting in ways that benefit all. The consequence of the correlation between performance and agent commitment led not only to the ‘people are our biggest asset’ slogan (Cabinet Office, 1999), but also to the dialogue of performance appraisal where an agent would negotiate an increase in performance through objectives and targets.

Hamilton’s (2004) discursive analysis of NHS managers, discussing an equal opportunities policy emphasises how the language of managerialism can advance and legitimise selected interpretations of the policy allowing it to be skewed towards organisational goals and not those of the workforce. In the case of healthcare where clinicians are becoming more and more dispossessed of corporate activities, managers as authorities of delimitation, represent the clinicians and speak on their behalf. Although Bourdieu (1991) maintains that the field is not independent and managers must appeal to their ‘followers’ to perpetuate their dominance and credibility, but there is fragility in such relationships and any suspicion will extinguish relations of trust.

The term management in itself is not necessarily an innocuous term. Grey (1999) contends that the term “*management...is not a mere convenience...the use of the word is not innocent and, in the case of management, its use carries irrevocable implications and resonances which are associated with industrialism and modern Western forms of rationality and control*” (Learmonth 2005: 618). Maybe in recognition of this seemingly derogatory image, New Labour, in 1997, sought to replace the language of commerce with language that reflected greater thoughts of collaboration and partnership working (Newman, 2003). The term *management* that had replaced the pre-Griffiths’ notion of *administration*, evolved further and “*it is improving leadership at all levels of the organisation*” that is promoted as “*a key ingredient in modernising today’s health services*” (NHS Leadership Programme, 2004: 4). The claim is that “*better leadership means better patient care and improved working practices*

*for NHS staff*” (2004:4); an axiom also recognised in *Improving Health in Wales* (National Assembly for Wales, 2001).

One might argue that the difference between the terms manager and leader is one of semantics (Dye, 2000; Parker, 1994) and it is not within the scope of this thesis to debate this in any depth, but this widespread normative change to the term *leader* in preference to *manager* in the NHS is conspicuous and maybe somewhat symbolic in its rhetoric (Bush, 2008), stimulating a commitment-based discourse and a more acceptable and harmonious image in its quest to achieve effective organisational performance through a modernist agenda. Professionals prefer to be led rather than managed (Kerfoot, 2002) and with managers conceived as being clinically remote (Jasper, 2002) to include clinicians in the leadership framework may have been assumed as returning the operation of the health service to their former gate-keepers, to those who could make leadership more locally meaningful and clinically responsive (Millward and Bryan, 2005).

### **Summary**

This section elaborates on the how the power of language, text and the status of the speaker are intricately enmeshed in creating a dominant perspective of reality and considers the way in which these dominant representations affect an agent’s position in society and how they reflect on themselves as a subject. My deconstruction of the language of managerialism reveals how health care reality is being defined through a lens that implies that performance, both clinically, professionally and economically, is less than optimal. Language mobilises rational and scientific modes of improvement and the persuasive language of participation and empowerment seeks to ideologically gain the legitimisation of agents for this performative objective.

However, within our discursively constituted CES the notion that agents are passive is inaccurate and the power harboured in language must thus operate in both directions, micro-level resistance is generated as a reciprocal response to their subjective interpretation of another’s statements. This interactive ontology denies the dualism of power relations and elaborates that power does operate

*within* the social body rather than from *above* and the nature of its operation is now considered in more depth.

### A Complex Adaptive Systems Perspective of Power - *Batman: The Dark Knight*

*“A system that does not trust people begets people who cannot be trusted”*

(Davies and Lampel, 1998:159)

What is acutely apparent is that positional and ideological concepts of power are not commensurate with the principles of Complexity and its quasi-structural relativity. The realist *a priori* image of power is denied in a post-structural framework, power is not a reified entity with materialist qualities; *a commodity, a position a prize or a plot* (Foucault, 1982) extinguishing any implication that it can be possessed and bestowed as ideological constructs would imply. Dualist ideological perspectives of power do recognise that power is an inter-relational phenomenon that operates through the vehicle of discourse (Jaworski and Copeland, 1999), but the predicament of ideological discourse is in its naive assumption that ideology can be fixed and imposed and that agents are not active in shaping their own practice; it cannot accommodate the characteristics of reciprocity, subjectivity, experience and interdependence. Power, when visualised as a fluid and systemic phenomenon, however, is significant in understanding how power is disseminated through a CES. Kanter's (1997) perception of power as *energy* is a fitting metaphor, in light of Prigogine's work, that although ostensibly reflecting a physical connotation, analogises the way power surges through a CES creating tension through discursive competition.

One might consider that strategies of power that aspire to engineer consensus aim to order relations of power, but in reality relations of power will never reach this position of equilibrium as its relational ontology will always create a power differential; an asymmetrical relationship, enabling some and constraining others and perpetuating micro-level resistance and struggle. Thus micro-level relations of power naturally maintain a CES at an 'edge of chaos' position, through the power of diversity, competition and strategising between agents and this supports the notion of adaptive tension, the essential pre-requisite for the

self-organisation, where relations of power relations act as a Complex Adaptive System, organising themselves into patterns of legitimised consensus that entertains the notion of democracy; organised complexity as social order.

The work of Bourdieu (1991) undoubtedly articulates this phenomenon where some struggle to maintain the status quo whilst others attempt to change it. This notion of competition precludes power from operating in a 'top down' direction as power effects will generate some reciprocity of behaviour, whether legitimised, resisted, tolerated or ignored, but what is impossible to ascertain is the extent to which this act of co-evolution is a conscious and purposive act. Bourdieu (1991) believes that the hexal dispositions predispose an individual to unconsciously act in a particular way, but there is not necessarily any fixity of action proposed in Bourdieu's hypothetical claim, as the intuitive capacity of agents will modify any repetition of response. The thought that agents are able to naturally compete and strategise suggests that managerialism is attempting to stifle this tension.

My examination of the power effects of language offers important aspects to understanding the power effect of discourse in engendering legitimacy in a CES, but Foucault's relational perspective of discursive formation and practice enables me to explore this in more depth. Foucault's (1972) analytic of discursive power proposes how discursive formations are able to exert discursive closure through knowledge and how closure attempts to control through specific representations and definitions of reality. What is crucial is for me to comprehend the impact of discursive closure on the characteristics of a CES.

### **Foucault's Amorphous Perspective of Discursive Power - *The Karate Kid***

The Complexity perspective of power reflects a fluid and co-evolving post-structural ontology, power is not mechanistic and imposed, but systemic, generated as a by-product of relational *différance*, it circulates amorphously within a social body, not from above it, like blood through capillaries, creating a field of force (Cousins and Hussain, 1984) and *reaching into the very grain of individuals, touches their bodies and inserts itself into their actions and*

*attitudes, their discourses, learning processes and everyday lives* (Foucault 1980a: 39). In contrast to ideology, Foucault's (1976) assertion that the agent is not passive transforms agents into the vehicles of power, rather than the points of application as realist perspectives imply. Power acts in the inter-subjective space (Foucault, 1977) and infuses the system through discursive practice and in this way *discourses can be both an instrument and an effect of power* (Foucault, 1979: 100).

Foucault (1972; 1979) contends that the statements of discursive practice in multifarious fields disseminate power via diverse truth claims acting strategically and attempting to generate practice that reinforces their discursive claims by silencing or marginalizing opposing claims. Bourdieu (1991) supports the view that an agent's practice is bound to the generation and pursuit of strategies that reflect their own interest and in post-structural thinking every agents' understanding of the world, and thus their interests, differ.

However, Fox (1997) elaborates that a post-structural ontology proposes three characteristics. Firstly, agents can only interpret surface knowledge and cannot directly access the deeper knowledge or the system of rules that govern the production of discourse. Secondly, the way in which agents experience surface knowledge is only through discursive practice and thirdly, no one group, dominant or suppressed, can possess the discourse or author it absolutely. Douglas (1966) explains; "*as perceivers we select from all the stimuli falling on our senses and select only those which interest us, and our interests are governed by a pattern making tendency*" (Snowden, 2007:4).

The fact that agents can strategise, employing the surface knowledge of discursive statements to suit their needs by reinforcing, resisting or destabilising a particular order indicates that discursive practice is never neutral but strategically aims govern the production of its own statements. This network conception of power therefore argues that discourse cannot occupy a singular functional position with regard to a particular infrastructure (Foucault, 1980a). Therefore although an agent may subjectively objectify a pattern of superficial unity of norms and values, a normative logic, their action is never predictable or

fixed, they have the ability to choose based on the multiple and diverse discourses that cross their habitus and even if their choice is constrained it remains open to their conscious self and the unconscious durability of their dispositional hexis (Bourdieu, 1991; Clegg, 1989; Dreyfus and Rabinow, 1982; Kincheloe and McLaren, 2005; Mills, 2003).

Discursive practice is a temporal, emergent and fractal phenomena not fixed or authored by any one individual or elitist group but self-generated within the interstitial space through interaction and the knowledge of the field. The superficial knowledge housed in discursive practice thus reverberates in a non-linear manner through, potentially, all scales of the system, to be subjectively interpreted and acted upon by others. Central to the relativist epistemology of micro-level power is its shifting and unstable expression ensuring that the truth claims of discourse are never absolute (Clegg, 1989) but co-evolve with the truth claims of other fields as they are filtered through an agent's self.

### **The Foucauldian Concept of Power/ Knowledge – *The Terminator***

My examination of the power effects constituted in language and text elucidated the normalisation and ordering of society from a linguistic perspective, where the ordinate sign attempts to privilege a preferential or ordered view of reality and thus engender discursive practice to legitimise and reinforce that order. This linguistic foreboding is however, transcended by Foucault's (1980a) concept of *power/knowledge* an interdependent hypothesis that clarifies that there is no simple relationship between discourse and the reality it attempts to define, as discourses are never neutral but govern the production of their own statements; "*Discourses are not about objects; they do not identify objects, they constitute them*" (Foucault, 1972: 42).

Central to the post-structural position is that all knowledge is political and that *truth is not something that exists independently of competing perspectives whose champions strive to isolate it and lay it bare* (Dumont Jr. 2008:18). Foucault (1972; 1980a) exposes the process of discursive closure, as by referring to a particular referential body of knowledge, discursive practice can construct the object by reinforcing certain truth claims whilst marginalizing others and it is



through an agent's acceptance of this subjugation of knowledge that the power effects of discursive closure becomes embedded in practice and exercised throughout a social network. Knowledge becomes the power to define and exclude by fixing the conception of reality through a field (Craib, 1992) and this would be significant in legitimising the normative logic of a context.

However, unlike ideological claims, there is no simple relationship between discourse and the reality it aims to portray, a meaning is posited, resisted and fought over (Clegg, 1989), like a sign, the concept it portrays reverberates through the system. However, once that knowledge is legitimised its axiomatic claims attain *a priori* status in a particular field (Foucault, 1972) and this contextualisation embeds an archival image and unity that reinforces this ordered reality; agent practice legitimises the objects of which they speak. Foucault's thinking clarifies that the intimate relationship between the power/e-power/knowledge dynamic is the source around which the self is constituted, supporting the post-structuralist view that the self is not pre-given or stable but constituted through discursive practice.

This reflects the phenomenon in a CES where legitimacy engenders fractal patterns of contextual rules that accommodate distinct hierarchies of knowledge. Foucault elaborates that, in discursive closure, the statements of discourse become grouped together through regular, often contextual, association, within a social system, generating what Foucault describes a *regulated practice* (1972: 80) reinforcing truth claims to what is judged valid and invalid knowledge and what can be spoken in a particular place and time creating extra-discursive order (Foucault 1972, 1980a).

Foucault (1976) describes how knowledge can be disqualified as naïve or inadequate or disguised within a functional framework, and argues that in modernism the local experiential knowledge, or *savoir de gens*, is masked or ignored, conceived as lower down in the hierarchy of cognition and science compared to factual evidence, or *connaissance* and this dimension is innate in the pervasive use of the phrase 'evidence-based' in NHS discourse. Lyotard's (1984) thesis *The Post Modern Condition* explores in great depth the way in

which scientific knowledge has risen in ascendancy, potentially unchallenged, throughout modernity to give the performative focus a respectable face. Lyotard (1984) claims that scientific knowledge habitually legitimises itself by appealing to a coherent meta-discourse; a corpus of documents that homogenise and intertwine dominant claims. However, Lyotard (1984) insists that 'narrative' or local knowledge is never lost, but continues to cluster within a network; it cannot be removed, it is constructed by them for them. This introduces a notion of sense making and may explain why managers and politicians, who cannot make sense of local clinical experience, in the NHS, subjugate it as irrelevant.

Foucault (1980a) thus replaces the notion of ideology with the concept *regimes of truth*, a concept that is much more powerful than a set of imposed and internalised beliefs formulated by an elitist group (Mills, 2003). Derrida (1976) indicates that différance is constituted in the self and able to modify behaviour, but regimes of truth are more than merely a way of seeing the world, they construct unified definitions in particular contexts of a particular social group to control behaviour (Knights and Morgan, 1991).

Foucault (1967; 1972; 1980a) demonstrates that the potency of *regimes of truth* is in their ability to combine with several bodies of knowledge, where discourses from seemingly diverse trajectories privilege a particular truth claim, in effect forming a network of statements that resonate together to describe the object in a particular manner, which Foucault (1972) describes as *grids of specification* and which ultimately generate the *dispositif*, (Foucault, 1980a) an intricate apparatus of power that transcends language but incorporates every feature of societal living; *a thoroughly heterogenous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative procedures, scientific statements, philosophical, moral and philanthropic propositions- in short the said as much as the unsaid* (1980a: 194). In other words, if one discourse fails to attain the required order another will join forces, blending scientific and economic discourses with the moral and ethical.

### **A Productive Connotation of Power – *Total Recall***

In echoing the CAS perspective of power, Foucault's (1977) thinking denies the negative, constraining connotation of power as implied in ideology and asserts that we must abandon the idea that knowledge is only produced when relations of power are suspended; altruistic or ethical motives and beliefs are not necessarily denied by practice, although there are theorists, particularly Bourdieu (1991) who would argue the true strategic nature of altruism.

Foucault's proposal portrays a positive and productive side to power that is of huge significance to the process of self-organisation and co-evolution as it removes the notion of the victim (Dreyfus and Rabinow, 1986). Power within discourse sets up a complex strategic relationship within each social grouping, where all agents can consciously vie for dominance, agents know what they are doing, even if they cannot predict the long term consequences of their actions (Dreyfus and Rabinow, 1986) and by doing so these relations of power engender the essential stimulus for practice that is novel, unpredictable, but within contextually accepted confines.

Mirroring a CAS, relations of power ensure that a system never reaches equilibrium. The power relations in a Foucauldian social system also promote a human analogy for Prigogine's (1997) work and his claim that a differential of power, in this case, generated through diverse claims to knowledge, catalyses the phenomenon of self-organisation in a CES; the combination of fractal rules and agent 'freedom' creates the mix of competition and collaboration on which self-organising behaviour is dependent (Cilliers, 1998). The power housed in these patterns of local behaviour is therefore vital to a social system because in each local context it provides a matrix of force at any given time for any given 'society' and ensures a system can transform its own functioning through the generation of new practice (Dreyfus and Rabinow, 1986).

### **Invisible Mechanisms of Power – *The Wrong Trousers***

Foucault's analytic of power in *Madness and Civilisation* (1967), *The Birth of the Clinic* (1973) and *The History of Sexuality, Volume I* (1979) centres on discursive formation and how truth claims reflect a body of modernist

knowledge, but his later work, *Discipline and Punish*, (1977) Foucault's is interested in the rituals of power that constitute an agent's discursive practice and the mechanisms through which power operates, the webs of unequal relationships and the regulations and rules that control the distribution, regularity and circulation of a set of cohesive statements (Dreyfus and Rabinow, 1986).

Foucault's critiques (1967; 1977; 1979) vividly describe how truth claims attempt to subjectify agents through the disciplinary instruments of power, hierarchical observation, normalising judgements and the examination; *the microphysics of power* (Foucault, 1977:26). Replacing the 'punitive' exercise of power, Foucault (1977) explains how power seeks to control through rehabilitative processes, exercised initially through disciplining measures and the infra-penalty, but claims how the transition into the unconscious self occurs when an agent's self becomes constituted by the knowledge claims legitimised by the field, generating what Foucault (1977) describes as a *docile body*, an unconscious patterning of behaviour that constitutes the very belief system of an agent's self, through the exercise of bio-power.

Foucault (1977) contends that punishment and detention, aimed at correcting behaviour, promotes hostility, recidivist behaviour and a powerful resistive cohesion within the subjugated; "*the power of the body does not weaken however it only retreats and reorganises its forces, investing itself elsewhere...the battle continues*" (Foucault, 1980a: 56). An interesting example of self-organisation that indicates that emergent properties can be both novel and unpredictable. However, bio-power is said to be the most sinister expression of modernist power, operating through the ability to judge others, a mechanism that slowly metamorphoses the self through self-reflective *gaze* (Foucault, 1976; 1977: 293); self-monitoring that culminates in an agent's behaviour and practice becoming the self-regulating and self-maintaining (Clegg, 1998; Foucault, 1979).

Foucault's concept of disciplinary power strikes an immediate resonance in the modern bureaucratic organisation (McKinlay and Starkey, 1998) and is

embedded in agent rich environments, like the NHS organisation, that fits a more organic rather than mechanistic model, where creativity and flexibility are essential attributes. Agent rich environments are characterised by a high level of autonomy and self-management and the viability and legitimacy of direct control is reduced by the agent's conception of autonomy entitlement and as such the introduction of disciplinary processes of control can be controversial and counter-intuitive to a learning environment (Barker, 1993: Alvesson 1993; Deetz, 1998).

Knights and Morgan (1991) make a significant contribution to understanding corporate strategy from a perspective of power contending that strategy located within *an emergent set of discursive practices* within which are *distinctive power effects on organisations and subjectivity* (1991:1). The authors argue that,

*“The emergence and reproduction of ‘strategy’ as an essential element in managerial discourse needs to be located in specific changes in organisations and managerial subjectivity, because it is a mechanism of power that transforms individuals [both employees and managers] into particular kinds of subjects who secure a sense of well-being through participation in strategic practices”* (1991:1).

### **Technologies of Hierarchical Observation - *Someone to Watch Over Me***

Foucault's (1977) illustration of Bentham's 'Panopticon' is possibly the most outstanding early example of surveillance that enabled prison guards to watch over their inmates from a glass observatory. The 'panoptic' mode of surveillance of society was embraced as an appropriate way to achieve order in any part of society and became a pervasive technique that remains to this day in many sectors, from manufacturing to schools to hospitals, where wards were designed so that the 'sister' could discretely oversee not only her patients, but also her nursing staff; *the microscope of conduct* (Foucault, 1977:173).

Foucault describes how the ordering of behaviour through the 'gaze' reverberates throughout a system, but more insidiously, Foucault (1977) suggests how the mere presence of the 'panopticon' manned or unmanned has

the same effect; the 'prisoner' constitutes the constraint within his self by internalising the behavioural code. Clegg (1989) explains that surveillance is not simply overt supervision, but manifests itself as routinisation, formalisation, mechanisation and legislation.

However Foucault (1977) unearths a more ominous and covert form of the *gaze* where the prisoners are assigned as supervisors as a 'trustee', an approach thought more favourable to maintain the discipline of one's 'colleagues'. Generating a pyramidal structure of surveillance, Hopper and MacIntosh (1998) consider that this form of surveillance spawned the hierarchical organisation, also serving as a functional mechanism to relay information to those in authority.

My initial reaction is to perceive an analogy of the 'trustee' in the role of clinical leaders in the NHS, replacing managers with their own clinical colleagues as a means to ease conflict and resistance. In academia, managerialism is identified as generating a *dissonant clash* between managers and staff creating a climate of either silence or aggression (Zipin and Brennan, 2003). In the NHS, research suggests that clinical leaders are "*forced to grudgingly accept the priorities that others impose*" (McDonald, 2004:161). Clinical leaders have emerged from the operant level of the organisation, they have experiential knowledge of the context and its specialist language, but more significantly they have 'social capital', a dimension that is grounded in relations of trust rather than rational authority, but one that is therefore extremely fragile.

### **Creating the Docile Body - *Coma***

The concept of disciplinary power is a more complex phenomenon than simply operating through conscious mechanisms and Foucault (1977) reveals a more subtle mechanism in the *docile body* when an agent's self becomes constituted by a normalising discourse. Foucault's texts (1971, 1977, 1981) expose numerous examples of how repressive and normalising discourse generate ritual marks of allegiance, where the body is 'broken down' and reconstituted by norms to create a homogenous, but artificial social order; the fabric of *capitalist man* (Gramsci, 1971). Rabinow (1989) clarifies,

*“Discipline increases the forces of the body (in economic terms of utility) and diminishes these same forces (in political terms of obedience). In short, it dissociates power from the body, on one hand and turns in into an ‘aptitude’, a ‘capacity’ which it seeks to increase; on the other hand it reverses the course of energy, the power that might result from it and turns it into a relation of strict subjection”* (Rabinow: 1989:182).

Foucault (1979) believes the ultimate privilege of such norms is to optimise the capabilities of an agent for work in a way that it would exploit its own energy, by repressing undesirable behaviour, lateness, impoliteness, inactivity, idle chatter, uncleanliness and ‘indecent’ sexual behaviour. The *infra-penalty* was devised where if norms were contravened and included minor humiliations and deprivations with the hope that agent’s would aspire to and achieve optimal behaviour. Thus the need for overt surveillance diminished, replaced by moral and ethical norms of conduct, a process Foucault (1986; 1988) describes as *self-inspection*.

This normative constitution of self culminates in an agent’s behaviour and practice becoming the self-regulating and self-maintaining and in some ways may determine the ‘attractor state’ or normative logic of the field (Bourdieu, 1991) around which self-organisation occurs. The outcome is a localised and legitimised discourse, a micro-narrative, *“a set of tacit rules that regulate what can and cannot be said, who can speak with the blessing of authority and who must listen, whose social constructions are valid and whose are erroneous and unimportant* (Kincheloe and McLaren, 2005: 310).

This technique is recognised in institutions, such as schools, but the creation of the docile body is almost an intrinsic characteristic of the ‘professional’. The advent of the professional and the inauguration of professional bodies, with their codes of conduct have made the norms a mandatory dimension of their evolving self. This mechanism of power is possibly epitomised by the role of the nurse, the need to appear self-sacrificing, compassionate and subordinate and the expectation to take on this role and not complain when they join the profession

(Salvage, 2001). In complete contrast is the aspired image of managers, charged with being rational, technical and organised; emotion must be avoided (Harding and Learmonth, 2004a; Dent and Whitehead, 2002).

### **Agent Conformance through Examination – *Terminator 2: Judgement Day***

The examination is the instrument that transforms the visibility of the subject over whom the discipline is exercised to confirm their conformation to the norms, thus perpetuating exclusion and difference (Foucault, 1977). In education conformance to a specific intellectual image is celebrated by ceremonial events such as graduation and in the military, there is the medal. In professionals the need for surveillance diminished as self-regulatory mechanisms became established, but in the contemporary NHS performance management and performance indicators are now the means to examine using an linear and rational, but intimate, process of workforce surveillance and comparison (Davies and Lampel, 1998; Fletcher, 1999) as epitomised by the '*Management by Objective*' (Drucker, 1954) 'culture'.

Appraisal systems make the agent more visible by auditing their activity in line with prescribed standards and deviations from the norm (McKinley and Starkey, 1998); *the individual person could now be known according to their contribution to the efficiency of the enterprise*" (Miller and O'Leary, 1987: 242). It is a process that drives into the very soul of the employee, becoming accountable for his or her attainments as the supervisor acts as the *judge, coach and counsellor* (Findlay and Newton, 1998; Hopper and Macintosh, 1998) valorising congruence. The employee actively participates in his or her own *improvement*, measuring their conformity against specific measurable goals and feedback actively seeks further improvements supposedly fulfilling both individual aspirations and organisational goals simultaneously. This is suggestive of the 'psychological contract', where organisational goals are turned into personal goals (McKinley and Starkey, 1998). Benchmarking is another mandatory surveillance mechanism introduced into the public sector from the private sector (Fowler and Campbell, 2001; Jones, 2001; 2002; Wait and Nolte, 2005; Wolfram-Cox, Mann and Samson, 1997) that aims to judge one organisation against the results of another.



Together with performance management, accountability constructs powerful discourse of surveillance that aims to control and discipline employees by surveying and comparing activity (Hopper and Macintosh, 1998; Hoskin, 1998) through a *normalising discourse that refers to an economic body of knowledge* (Hoskin, 1998:106) In education, Cannon (2006) relates how his failure to follow a rational strategic approach to attaining organisational goals, even though goals were achieved, was met with a negative response by inspectors, causing him frustration and resentment and although Cannon weathered the storm, others may have been more submissive in towing the dominant line.

### **The Necessity of Documentation - *Spies Like Us***

The emergence of documentary records and the ‘information’ society became a secondary effect of the surveillance and examination, through the building of archival documents, generating bureaucracy and the need for efficient methods of storage and the retrieval of data; agents became statistics (Felluga, 2003) and the document exercised power through surveillance. Dandeker (1990) elaborates that surveillance activities include the deliberate collection and storage of information about people and the supervision of activities through the issuing of written instructions. Dandeker (1990) suggests that over time supervisory and data gathering activities are mutually reinforcing and comprise the relationship between the rulers and the ruled, behaviour becomes routine relationships of command and control.

In medicine, the medical examination and the codification of disease states and medical conditions established formalised conditions, now subjected to treatment by evidence-based guidelines. In the field of primary care however the quantitative recording of medical conditions and their treatment has now taken on a new political complexion through the surveillance activities of the Quality and Outcomes Framework (QOF) (DOH, 2008) that cannot necessarily adjust for clinical judgement. However, in actuality this codification and categorisation is the re-enabler of clinical power by virtue the differentiation of numerous medical and surgical specialities, constructing a dictionary of vocabulary not only unintelligible to the lay public, as Foucault suggests (1977) but also to the

healthcare manager. One might consider that the medical and nursing professions, as the traditional gatekeepers of the NHS, remain endowed with considerable power to privilege their own interests by employing the power of specialist knowledge. As Foucault (1977) suggests, a positive aspect of power can come from the negative, even though the past twenty years has witnessed the increasing dominance of both political and managerial discourses of surveillance as the means to invert this relationship.

### **Summary**

Foucault's works allows us to acknowledge the productive aspects of power relations and how this predicated the existence of a naturally flexible, innovative and creative environment. However, Foucault reminds us that discursive statements act strategically and his analytics of power reveal the mechanisms by which the privileged knowledge of discourse combined with the power of the speaker and the legitimacy of text, can create closure in the attempt to dominate discursive practice to such an extent that it ceases to allow any freedom of choice.

This loss of adaptive and flexible behaviour must raise a concern for the operation of health care and therefore I return to my exploration of the major governing discourses of the NHS, managerialism and clinical governance, to examine whether they are acting as *regimes to truth* and exercising power through discourses of disciplinary control and surveillance. For the secondary care sector removing the power differential, by prescribing conformance and neutralising resistance may be destroying the natural, but essential, tension that allows the organisation, as a CES, to be adaptive and aware.

### **Revealing the Microphysics of Power in NHS Discourse - 1984**

Turning my attention back to the major governing discourses of the NHS, I now explore the privileges concealed within their discursive statements. Chapter two suggests that politicians act as authorities of delimitation, who speak on behalf of healthcare and thus define its notion of success and its relations of power. By effectively ordinating their status above managers and clinicians, politicians enshrine an image of the NHS through documents that constantly refer to

inefficiency and variability and in doing so exclude any contrary interpretation. The question is whether this strategy is to justify an approach to reform that promotes the necessity of cascading mechanisms of surveillance, not perhaps as palpable as panopticism, but through methods that are as effective in stimulating conformance in both clinical and managerial audiences?

### **NHS Discourses of Hierarchical Gaze – *Room with a View***

Although there is no quarrel about the need to use scarce resources effectively, there are several aspects of NHS discourse that stimulate a concern regarding increased surveillance and the loss of diversity and voice. Predominant in this respect concerns the de-professionalisation of tasks to lower grades of staff, a practice change that allows for a greater degree of direct agent surveillance. Perhaps validated by clinicians as a seemingly logical and rational approach, surveillance is not operated through managers, but through the clinicians themselves. Whether this amounts to a ‘trustee’ approach is difficult to judge, as it does not suggest any re-constitution of the non-professional self, but in relation to the habitus would drastically transform the normative logic of the field and its patterns of working.

What clinicians are also validating, through de-professionalisation, is the move towards a scientific discourse of linear and mechanistic systematicity that controls behaviour through a rigorous set of procedures. One can recognise how this managerialist doctrine is reinforced from a separate trajectory, as the statements of clinical governance ironically bolster the universalisation of processes from a patient safety and quality aspect, under the guise of quality as minimising service variation.

Of concern, however, is that the profound consequence of de-professionalisation is the loss of knowledge. Non-professional workers do not have the *savoir* or *connaissance*, the experience or factual knowledge, to use their own judgement, and as such the shift in practice diminishes the autonomy and adaptive capability of the clinicians in the system. It is a shift that supports the arguments made earlier that doctors were thought to wield too much power in their ability to obstruct political reform (Harrison, Hunter and Pollitt, 2003). To suggest that

this delegation echoes the thoughts of Marxist *proletarianisation* may be a little harsh but reflects the situation where clinicians, stripped of direct control over their work, become less able to act in resistance (Friedson, 1994).

The discursive web is also interweaved with the emergence of national guidelines that remove the need for the clinician to use their clinical judgement, a privilege now portrayed as a risk to patient care (Baker, 2000; Whitfield, 2000). The anomaly is that accompanying the process of delegation is the need for risk assessment, which counters its own argument, but generates accountability through documentation that can be audited and compared. This pervasive process of scientific devolution is also transferring the focus from patient to task and relying on the notion of ‘best practice’ and therefore endorsing ‘past practice’ by not stimulating the freedom and authority to adapt or innovate. Marginalizing intellectual knowledge through devolution thwarts the stimulus of critical reflection that keeps a system flexible, responsive and safe by removing the *savoir de gens*.

### **Creating the Docile Clinician - *Robocop***

The most potent disciplinary discourse revealed in the clinical discourses explored in our NHS context reflects the concept of the docile body. The impact of discourse that surfaces from the professional field are undeniable in the shaping and patterning of practice (Gunnarsson, Linell and Nordberg, 1997). Health care professionals are normalised, superficially at least, with respect to dominant norms and values and formal and informal expectations of conduct that constitute the archival unity of the profession, a Hippocratic oath or a code of practice that constitutes the notion of a professional self (Garman, 2006; Miztal, 1996; 2002). Although ideological in its construction, the aim is not to suppress or subordinate, quite the opposite, as it manifests as an innate work ethic and commitment for their role that supports the premise of self-regulation and autonomy (Davis, 2002; Flynn, 2002).

As a clinician, I find it difficult to gauge the extent to which these norms and values are consciously or unconsciously inscribed in the self. In some ways it is a unity of discourse that health professionals have come to expect when they

join the profession and thus legitimise the need to repress alternative behaviours, overtly at least. It reflects a thought expressed by Hoschild's (1985) concept of *emotion work*, a notable form of conscious dramaturgical exchange where an agent would feel obliged to act with compassion and empathy to cement a relationship, but in many clinicians it is as likely employed to satiate a patient's need than any concern for organisational credibility.

(Un)fortunately, the autonomous standing of the 'professional' in the organisation together with a highly specialised body of clinical knowledge engenders social closure, status and monopoly which affords a high degree of power in their ability to resist conflicting discourse (Friedson, 1994; Reed, 1989) although Brooks and McDonald's (2000) research concludes otherwise. The authors research in nursing indicates that professional fields are not in isolation and discourses co-evolve demonstrating that nurses who work by day have legitimised an inter-discursive managerialist-clinical mix in their day to day activity to an extent where they scorn their colleagues who work at night; night staff would be much more isolated from both the language and privilege of managerialism. Similarly Hau (2004) suggests that managerialism, in Singapore, is able to re-direct and ordinate nursing practice towards efficiency and throughput and away from the clinical focus.

However, it is pertinent to note how clinical governance discourse (DOH, 1998; 2000) cites self-regulation and the lack of direct surveillance as a proposed reason for the failures and variations in care, but we must note how these statements are enunciated and documented by those with political authority. One might consider that clinical governance generates a new concept of health care reality for the public's eyes that suitably undermines and unnerves the confidence of the doctor-patient relationship, allowing political discourse the power to take control of the situation by removing the concept of self-regulation and replacing this with a more direct route of surveillance (Department of Health 2006, 2007a; 2007b). The relations of power have thus been skilfully re-shaped through the removal of the power from the clinicians, dissipating their authoritative voice in their ability to 'speak of truth' and their freedom to act autonomously. The intricacy of the web extends as clinical governance

reinforces the discourses privileged by managerialism by allowing managers to the authority to direct and oversee their work, through the techniques of systematisation, performance management, benchmarking and clinical audit (Halford and Leonard, 1999; Rosenthal, 2002).

Further removing confidence in the normalising codes of conduct that constitute the professional is the frequent application of the concept of *professionalism* (Royal College of Physicians, 2008; Stern, 2006; Egan and Surdyk, 2006; Wear and Aultman, 2006). At its heart the concept professes expertise and altruism, regarded more superior than merely specialised workers, their discipline is thought of in vocational terms where they perform tasks of social value (Friedson, 1994). In stark contrast Larson (1977) perceives the phenomenon of professionalism as; “*a strategy of social closure...a set of interrelated processes and mechanisms for mobilising power in defence of collective control of a group’s share of rewards or resources*” (Reed, 1989:161) and reflects Bourdieu’s theory of ‘capital’ and its ability to access power and autonomy. Larson’s portrayal of social monopolising that denies or controls entry into a particular field (Friedson, 1994; Harrison and Pollitt, 1994) is epitomised in the discipline of medicine, who until recently exercised control over their own activities and even the status of other health care colleagues (Friedson, 1994; Johnson, 1972; Harrison and Pollitt, 1994).

However, a modernist shift in the definition of professionalism exercised through statements, such as the mission statement, emphasises that professionals are expected to reflect on their behaviour and harmonise not only professional and patient interests but also corporate goals and assumes a re-constitution of self that would avoid any likelihood of inappropriate or conflicting behaviour that counters the economic challenges of the NHS (Friedson, 1994; Wear and Aultman, 2006).

Re-negotiating the terms of organisational ‘commitment’ towards a performative focus may drastically impose upon an agent’s dispositional hexis and could risk alienating members completely (Parker, 2002). This discomfort and retaliation is recognised in academic circles (Briggs, 2005; Levin, 2005;

Whitehead, 2005; Zipin and Brennan, 2003) and this may be repeated in healthcare if clinicians feel their autonomy and ethical dispositions are being compromised or eroded by the performative rationale of managerialism. As Bourdieu (1991) reminds us agents chose careers that are commensurate with their dominant values and beliefs and where they can share these values and beliefs with others.

At this point, it may also be appropriate to explore the underlying discourse in the concept of *empowerment*, as its rhetoric is rife in contemporary NHS management discourse. Ripley and Ripley (1992) see *empowerment* as acknowledging the talent and creativity of individual employees, but its statements mimic one of control by reducing an agent's resistive practice without necessarily giving the employee any influence, power or autonomy only the responsibility for their own failure, a clear example that reflects the *technologies of the self* (Foucault, 1988). McDonald's (2004) critical inquiry into the experience of clinical managers identifies how the move to empower staff within a highly top-down NHS secondary care organisation is merely a rhetorical device that attempts to "*force staff to accept the priorities that others impose upon them*" (2004:161).

The academic literature indicates how the landscape of secondary care is transforming from one where clinicians were seen as capable of exercising their own clinical judgement through self-motivated and self-regulating practice to one where this autonomy has been disrupted through fundamental shift in the patterns of governance through two governing discourses that privilege a discourse of surveillance and accountability. The explosion in audit and performance management in health care echoes the Foucauldian (1991) concept of *governmentality*, a *disciplinary regime* (Power, 1994) of power operated through language, where the language of audit takes the dominant stance.

Governmentality aims to guard against emergent complexity (Kernick, 2002) by pervading society with systems of regulation, concerned with the *conduct of conduct* where the government is not necessarily the state apparatus of power but the decider of 'political rationalities' able to define the issues and problems,

of clinical risk. In the case of clinical governance it has created a reality steeped in variance, failures of care and incompetence that professionals are legitimising through discursive practice. Turner (1997: xv) considers that governmentality “*links self-subjection to societal regulation*” where the professionals themselves formulate their own referential knowledge and reinforce this through their practice, exercising their own ‘constraints’. I clearly recognise this concept by the way in which the Nursing and Midwifery Council (2004) have constituted their code of practice with the need for documentation; a lack of documentation is considered incompetent and unsafe behaviour (Daniels and Kydd; 2007).

### **Examining Secondary Care - *Please Sir***

Accountability is a powerful act of surveillance, where ‘accountants’ speak with authority, aiming to control and discipline by surveying and comparing activity, through performance management, audit and benchmarking, that privilege organisational and political goals (Baker, 2000; Hopper and Macintosh, 1998; Waite and Nolte, 2005). In the secondary care sector this act of judgement cascades through all levels, politically and organisationally, where one acts as coach and counsel to generate congruence to the norm. Structured performance assessment is not widespread in clinical fields although this is likely to increase with the introduction of the Consultant Contract (Department of Health, 2004a) and the Knowledge and Skills Framework (DOH, 2004b) that operate through a ‘management by objectives’ philosophy. Clinical audit has also gained a superior position, replacing the notion of peer review as a means to assess standards of care through what Power (1998) suggests is a luxurious, passive and retrospective examination, that makes doctors decisions, with hindsight seem misplaced, even though they were effective at the time.

Ultimately discourses of accountability exercised through examination do little to remove organisational hierarchy or self-interest, essentially reinforcing rational authority and conformance by persuading agents to conform rather than resist, stabilising the relations of power on which the CES depends. It may be understandable why evidence suggests that managerialism reduces collaboration, trust and motivation and counters any desire to adapt and innovate



to the dynamic needs of the service (Gilbert, 2005; Horton, 2003; Pollitt, 2003; Seddon, 2005).

### **The Power - Trust Dilemma in Health Care – *Blind Faith***

The expectation in the NHS is that all agents are able to trust one another; policy documents and strategies insist that we do, as it is pre-requisite for an efficient and collaborative workforce and team working (Beecham, 2006; Welsh Assembly Government, 2007b). Political discourse reflects Mitztal's (1996) determinist comments, that trust is a *social lubricant* solving the problems of collective action and generating a confidence that 'one' will not be exploited. Mitzal (1996) states that trust is thought a necessary factor for economic success.

The concept of power has traditionally been placed polar to the concept of trust. However unlike power, trust does not have the same systemic and circulatory ontology, it is not necessarily acquired through position and although the notion of entrusting someone gives trust a commodified and material status, it remains an essentially emergent property between two people, a product of their evolving social interaction and intensely sensitive to the context in which it emerges (Bauman and May, 2001). Trust is not a linear and deterministic phenomenon; you cannot inscribe trust through political discourses that preach partnership working and organisational commitment.

Bauman and May (2001: Ch5) explain trust through the principles of *exchange* and the *gift* and transcends mere functional action by generating emotion, altruism and moral satisfaction. At a local level, trust is a vital factor to enable connectivity and the reciprocity of relations and collaboration and learning on which any self-regulating system is reliant (Jacobs, 1993, Adler, 2004; Lave and Wenger, 1991). Trust can also enhance the feeling of belonging necessary for transparency, critical reflection, even when reputations may be at stake (Cohen and Prusak, 2001, Adler and Elmhurst 1999; Nonaka and Takeuchi, 1995, Fox 1994). Healthcare, at the clinical level is a highly inter-relational, emotional and intimate environment and the unpredictable, risky and ethical nature of their work requires a need for trust to maintain a reflective, responsive and safe

environment (Watson, 2002b). It goes beyond thinking; thinking is objective, impersonal and logical but feeling is more in harmony with the socio-centric and moral values found in clinical fields.

Essentially the autopoeitic ability of professionals to self-maintain their environment is dependent on their autonomy. The knowledge of the specialised fields is their unique capital and can control the balance of power within the organisation. I chose the metaphor *autopoeitic* deliberately as, in reality, fields do attempt to draw boundaries to create discursive closure, shutting out perturbations that threaten trust through a shift in power relations. Trust is perilously easy to destroy and the techniques of surveillance and examination, however justified, can clash with expectations of professional autonomy (Adler 2004; Watson, 2002b).

Attempts to generate relations of trust through ideological discourse can undermine the true social nature of trust (Bauman and May, 2001), but in the secondary care context there is a conflicting mix of discourses. The ideological belief in commitment, shared values and trusting collaboration is being thwarted by a shift from self-regulation to a higher level of direct hierarchical control, weakening autonomy and engendering adversarial 'relations of production' that are essentially low-trust; high trust relations are perceived as culminating in self-interest and competition, but even self-interest of doctors in their research activities is thought a conflict of interest to organisational goals (Adler 2004; Kernick 2002; Feldheim, 2007).

Foucault (1982-1984) briefly transfers his explorations of power to the notion of trust, in his unpublished lectures, explaining that the truth claims of a speaker are validated through relations of trust engendering an interdependent relationship where validation maintains the speaker in a pedagogical position (Luxon, 2004). Foucault calls this *parrhesia*, or *fearless speech* (2004: 464) which Foucault conceptualises as a micro-level democratic practice that echoes professional obligation, in its ethical, intellectual and collaborative search for the truth, by challenging patterns of practice and thinking, opposing any exclusion of knowledge. Foucault explains how through relations of trust

relations of care emerge; *the aesthetics of existence*, as the audience recognises how the speaker's frank expression may risk political and personal reputation further substantiating the claims to truth. Confession rather than being treated with a punitive response is an unburdening and liberating experience.

I wonder to what extent this parrhesial frame of reference exists in the clinical context. The peer review process in medicine, sadly waning in the face of audit, assumes transparency, harmonising open reflection with power relations expressing a mix of jousting and parrhessia, as they challenge each other's established practices. It may be a discourse that promotes the genuine progress of knowledge, but is at risk through its stark opposition to the surveillance processes of managerialism and clinical governance.

### Conclusion to the Chapter

This chapter has repositioned the concept of power from a traditional commodified or positional connotation by elucidating on the limitations of realist and dichotomous models as attempted by managerialism. It has allowed me to re-think power through a post-structural ontology, an inter-subjective and relational phenomenon, continually under formation and expressed through the statements of discourse, discursive practice. Epistemically this re-conceptualisation offers a convincing and profound framework with which to explore and understand the aspects of agency, self-organisation and co-evolution in a CES where the dimensions of agent diversity are celebrated rather than removed.

Foucault's work allows an appreciation of the productive nature of power where a power differential is essential to engender the adaptive tension that keeps a CES operating at a far from equilibrium position, stimulating fractal patterns of self-organising behaviour and thus maintaining system viability. The significance for management practice is that whilst a discursively constituted system continually competes it questions the belief that system equilibrium should or could ever be achieved through any control based discourse that seeks to repress this creative potential. However, it seems the discourse of managerialism is hopelessly bound to health care policy; a mere pawn in political hands; their symbolic violence constructs the rational and scientific

discourse of managerialism, building in an intimidatory discourse of surveillance in those who are predisposed by their role.

In applying this framework of power to the two major governing discourses of health care the inference is that statements of seemingly diverse discourses not only act as regimes of truth, but converge, each reinforcing the other, strategically unifying a modernist focus that promotes conformity to political imperatives through a subtle exercise of power that not only controls bodily but drives into agent self, constituting their very soul.

What I am beginning to recognise is the beginning of a *dispotitif* for secondary care, endorsing conformity through regulation and surveillance from political, managerial, public and professional angles, perpetuating organisational hierarchy and removing intellect from the front-line, simultaneously threatening an environment of trust, motivation and collaboration. The critical question that must be addressed is whether the NHS is truly being engulfed by the power of the *dispotitif*. Bourdieu (1991) argues that such dominance presupposes complicity in those who are expected to submit, but this wreaks a potential scenario that must generate concern within all circles of the NHS and for those who aim to improve performance as the *dispotitif* will engender passivity in those exact individuals who are expected to keep the system adaptive and safe and in innovating new ways of working and thus Foucault's work offers a distinct variation to understand why adaptive and innovative practice is not emerging.

Foucault's concept of power/knowledge demonstrates that it is through diverse influences and local negotiation that new knowledge and innovative practice is generated and rules out the need for the conformity and control where diversity and conflict is silenced. System transformation occurs where diverse prerogatives continually jockey for position, through agent practice, behaviour and belief systems. A locally negotiated and legitimised discourse is powerful in its ability to build in influences from many discourses. Thus agent diversity must not be viewed as destructive, but as an innate organisational characteristic that stimulates the tension needed to generate new knowledge through

collaboration and negotiation. However, I must assert that my conclusions are merely subjective speculation at this point and my concerns may not be borne out in practice. Hence, the ensuing stage of this thesis to actively engage with agents in the secondary care context to investigate the extent to which the modernist focus is inter-discursively (re)constituting the self, distracting negotiation and co-evolution through mechanisms of discursive closure and whether this is counter-intuitive to maintaining an adaptive, innovative and safe environment.

**Chapter 5:**  
**Crafting a Methodological Framework**  
*- Close Encounters of the Third Kind*

## Introducing the Chapter

The purpose of this chapter is to design a methodological skeleton that can support the relativist and discursively constructed nature of my secondary care context, a 'frame of reference' that is pliable and adaptive in its ability to fit its polyphonic (Clegg, Kornberger and Carter, 2003), temporal (McMillan, 2004; Mitleton- Kelly, 2003a) and ambiguous nature (Davis, 2004; Sarup, 1988). It is the character of complex human contexts that they continually breach theoretical constructs (Craib, 1992) and thus they require a methodology that can accommodate the richness of their environment; complex, pluralist and divergent; complex through intricate interaction, pluralist through diverse views, values and beliefs and the ability to tolerate another's views, values and beliefs and divergent in the ability to engender tension through innate relations of power (Jackson, 2000).

I begin this chapter by inquiring after the true constitution of knowledge and with a brief critique of the dominant methodological paradigms that inform traditional management research. By (re)focusing on a *phronetic* (Flyvberg, 2001) route of inquiry, I seek the means to explore the aspects of lived experience; the secondary care context as a *sensual and emotional realm*, replete with ceremonies, rites and dramas (Turner, 1990:89) where reality is subjective; *novel, emergent and filled with multiple, often , meanings and interpretations*" (Denzin, 1983:133).

In choosing a post-structural and critical approach (Foucault, 1972; 1980a) my 'framework' aims to explore the relationship between power and knowledge, seeking the ways in which particular discursive statements constitute the selves of agents in the field, influencing the course of discursive practice. A central aspect of the post-structural position is to address the ethical and political dimensions of discourse with the view to making a tangible difference (Dumont Jr. 2008) by revealing whether the statements of discourse act as *regimes of truth* (Foucault, 1980a; Kincheloe and McLaren, 2003). The chapter continues by elucidating on my choice of Foucauldian discursive analysis as the means to explore how dominant statements infuse an agent's self, whether statements constrain knowledge and potentially distort or distract discursive practice

towards a particular centre of attention and to ultimately understand the impact of the power- knowledge relationship on my context as a CES.

For minds, like mine, who have historically legitimised scientific knowledge and the positivist paradigm, accepting alternative claims to truth can be disquieting, but my relativist position allows us as scholars to intellectually accommodate that there is no universal standpoint and no finality to knowledge (Kincheloe and McLaren, 2005), enabling us to debate the value of alternative but equally valid conceptions of complex human systems with philosophical indulgence and expectation.

As a post-structuralist, I also challenge the notion that as researcher I am able to stand objectively apart from my context and accurately report, or linguistically portray, as author, any universal representation of the secondary health care sector (Denzin, 1989; Denzin and Lincoln, 2003; 2005). Released from objective dualism I situate my self within the research process understanding and accepting that my historically constituted habitus will shape the inquiry and guide my reflexive interpolation (Dreyfus and Rabinow, 1986; Gill and Johnson, 1991; Stacey, 2003a).

I consider myself a 'researching professional' as opposed to a 'professional researcher' and as such my self is myopic and inextricably located in the secondary care micro-level. As a consequence I am required to redress the concepts of validity, reliability and representation (Denzin and Lincoln, 2003, 2005) and yet I consider this rich subjectivity only compliments the credibility of my interpretation (Gill and Johnson, 1991). Gill and Johnson's thinking aligns with my own thoughts that to objectively and empirically research a context of which you have no experience may result in reductive abstraction. Thus I aim to act as emancipator, advocate and agitator as I interpret my findings through my own subjective experiences of a secondary care context.

The methodological 'framework' that emerges as the chapter continues does not intend to offer any predictions, nor necessarily produce any explanation other than my own subjective inferences, but is able to provide a forum to evoke



debate regarding secondary care health care management and the perceived ways in which agency is determined through the power effects of dominant discursive statements. The final part of the chapter elaborates on contextual sensitivities, introducing and explaining my choice of a minimally structured biographical narrative approach (McCracken, 1988; Wengraff, 2001) to provide a canvas for a *polyphonic collage* (Bakhtin, 1985) of selves. This method is premised on the understanding that agent's worlds are full of different voices, vocabularies and dialects; there is never one story about the world (Bakhtin, 1985).

### Recognising the Dimensions of Knowledge – *The Name of the Rose*

*There is no real end to methodological analysis, no hidden unity to be grasped”*

(Levi-Strauss, 1966:6)

My choice of critical inquiry makes reference to the Kantian questions, *what is knowledge?* And; *what can we know?* These questions are extremely pertinent for the atypical philosophical positioning of the thesis and I feel a distinct need to substantiate its standpoint.

As I recollect, Aristotle defines three intellectual realms of knowledge, *episteme*, *techne* and *phronesis* (Flyvberg, 2001) and this next section examines these in relation to the generation of knowledge with which to inform management practice and discusses the limitations of studying the organisation, as a discursively constituted CES, using deductive and objective methodologies.

### **The Value of Knowledge - *The Others***

Historically catalysed by a capitalist imperative and the Enlightenment episteme the pragmatic inclination of science is a persuasive discourse that dominates research in business and management promoting knowledge as *episteme* and *techne* (Carlisle and McMillan, 2006; Larsson and Lowendahl, 1996; Lyotard, 1984). It mirrors the paradigmatic rigidity prominent in the discursive statements of managerialism that requires the generation of knowledge that is determinist, functional and linearly applicable (Learmonth, 2004), *practical solutions to practical problems* (Burrell and Morgan, 1979: 26).

I admit that I have personally experienced and suffered from the domination of this conception of knowledge, where departmental priorities were redefined to address the massification of services through mechanistic and linear science and discourses of surveillance and control; performativity (Lyotard, 1984) is given primacy; “*the belief in the veracity of objective systems of accountability and measurement rather than subjective judgement and specialised knowledge*” (1984:11) culminating in a situation, clearly recognised in NHS discourse, where *evidence* is becoming increasingly central to contemporary strategic governmental policy (Byrne, 2005) and in directing and controlling professional activity (Flyvberg, 2001).

The discursive closure created by orthodox methodologies (Denzin and Lincoln, 2003) contrive to present a coherent and respectable image about a body of knowledge that is messy and complex (Knights and Wilmott, 1999) but as Hearn and Parkin (1987) contend, closure engenders a *booming silence* (1995:4) shrouding the exploitation, surveillance, manipulation and sexuality that are commonplace in organisations (Learmonth, 2004). The notion of *evidence-based management*, appeals to the ideals of managerialism, promoting an allegiance to scientism, through the belief that evidence, as objective knowledge and accrued through ‘scientific’ methodology can reinforce the effectiveness of managerial decisions (Hewison, 2004; Learmonth and Harding, 2006). Competency is now judged as rational, rule-following behaviour, masking the aspects of experience and intuition (Flyvberg, 2001). Learmonth (2006) exclaims that the political intrusion into academic research has threatened any approach deemed unscientific and in frank debate, Learmonth (2006b) critiques Rousseau’s (2006a) faith that evidenced based management research would “...[move] *professional decisions away from personal preference and unsystematic experience toward those based on the best scientific evidence*” (Rousseau, 2006a: 256) “... *countering the current organisational research bias toward novelty and fragmentation.*” (Rousseau, 2006b: 1091).

Learmonth’s (2006a; 2006b; 2004) critique is just as the political bias of knowledge is demonstrated at length in Foucault’s (1967; 1972; 1976; 1977;

1979; 1980a) work; researchers are duped into becoming a *servant of power* (Watson, 2002a: 22). One only needs to review the literature from pharmaceutical research to realise that the Randomised Controlled Trial, the pinnacle of scientific excellence in medicine, can easily suffer from the what Habermas (1975) describes as the *crisis of legitimisation* (BBC, 2007b; Drummond *et al*, 1998; Institute of Medicine, 2003; Kameron, 2007; Roberts, Smith and Evans, 2007; Young and Godlee, 2007).

In the pursuit of 'good' management research, the British Academy of Management and the British Journal of Management continue to engage in profuse and active debate about its constitution and mirrors the concerns of sociology about the decline in status of objectivity and the increase in methodological fragmentation (Bernstein, 1976; Gouldner, 1971; Greenwood and Levin, 2003). Paradigmatic deviance does stray, sometimes unwelcome, into management research (Pfeffer, 1993; MacLean, MacIntosh and Grant, 2002; Starkey and Madan, 2001; Reed, 1989; Tranfield and Starkey, 1998) and I expect that the reflexive, socio-centric and trans-disciplinary mode of inquiry of my research may well perturb the *intellectual poverty and practical impotence* (Reed 1989:176) of prevailing management thinking.

Therefore, I urge you, as a reader of this thesis, to question the anorexic systems of thought that constrain, determine or order subjective experience (Fletcher, 1999) through the application of reductionist methodological processes and to reconsider the an approach that acknowledges knowledge as context-specific, diverse, dynamic and evolving with a discursively constituted CES, where the power of human agency and the tension of innate relations of power continually reformulates and adapts knowledge in a way that accommodates heterogeneous claims to truth.

### **The Necessity of Phronetic Inquiry in Management Research - *Bicentennial Man***

In management research, the dominance of *episteme* and *techne* overshadows and subjugates *phronesis* in the epistemic hierarchy (Bourdieu, 1970; Denzin and Lincoln, 2003; Flyvberg, 2001). *Phronesis* translates as prudence, the

discovery of what is ethically practical and is deemed an essential component for enlightened political, economic or cultural development (Flyvberg, 2001). Cameron *et al* (1999) believe that the search for knowledge should encompass the aspects of *ethics, advocacy* and *empowerment* (Jaworski and Coupland, 1999) and should *carry out its interpretation with regard to the values and interests of society, aiming at social commentary or social action* (Flyvberg, 2001:60) and this phronetic concept should be contemplated for any organisational context as a complex interactive human system. The epistemological question that arises is the ethic of translating determinist and instrumental knowledge to management strategies that remove critical dialogue, collaboration and equality (Greenwood and Levin, 2003) in an attempt to cybernetically engineer the complex world of agency and behaviour.

I must interject at this point or be criticised for hypocrisy, as the underlying motive of Complexity remains orientated around a capitalist privilege, but my research posits that the dominant discourse of managerialism detracts from the necessary ‘freedom’ a complex human systems needs to flourish and I see Complexity as providing a phronetic route to success, by respecting and not marginalizing, the polyphonic voices of the organisation. Thus my phronetic objectives aim to stimulate the thinking of anyone who inter-relates with the contemporary world of the NHS: *a discourse that has the power to take us out of our old selves by the power of strangeness, to aid us in becoming new beings* (Rorty, 1980:360).

Flyvberg’s (2001) allegiance to the phronetic search for knowledge focuses on two main questions that form the backbone of this thesis. Through what kind of power relations does inequality and control occur in managerialism? And, is it desirable that this is allowed to happen? Like Foucault, Flyvberg (2001) asks what rationality and norms are at work, allowing those who govern, to do so. Flyvberg’s interest is not only who has the controlling power, but also why they have it and believes that answers lie within the minutiae and events of everyday life, exploring how reality is constructed and played through a discourse that unifies power relations in a particular direction. A CES requires that the micro-level powers of polyphonic voices are able to circulate through all scales

creating the edge of chaos conditions in which self-organisation and transformational change can occur.

### **The Limitations of Objective Epistemology - *Memento***

Because of its evolving nature, non-linearity, contextual differences, multifarious variables and the high level of interaction the positivist approach to studying complex human systems is ineffective (Eoyang, 2001; Richardson, 2005). It is impossible to be objective, according to rational terms, rigorous or systematic, according to scientific terms, or for conclusions to be accurate, generic and cohesive and free from researcher bias and self (Gell-Mann, 1994; Guba and Lincoln, 2005). Positivist research is evaluated in relation to a norm and therefore judgement about what constitutes knowledge is always subordinated to the person who institutes those norms (Bourdieu, 1991; Canguilhem, 1975 in Gordon, 1998). My philosophical framework questions the reification and homogeneity of the organisation and thus raises huge epistemological and methodological issues for positivist and scientific modes of inquiry (Burrell, 1998). Burrell (1998) argues that the term *organisation* attempts to reduce heterogeneity by *spuriously elevating similarities* (1998: 24) into normalities and the derision of this homogenous attitude is sensed in Foucault's (1979: 83) comment; "*Prisons resemble factories, schools, barracks, hospitals, which all resemble prisons*".

Moving away from deductive science into the field of interpretative study, I continue to meet realist epistemological dilemmas. Interpretative sociology is haunted by the metaphysics of presence (Denzin, 1989) that my post-structural position denies. Ontologically the relativist self is not located in a structured 'society' but exists at the micro-level, in the inter-subjective space and thus is not epistemologically constituted as an object through knowledge; there is no fixity or finality to meaning in a relativist system as meaning is merely constructed around opposition and difference and interpretative methodology remains subjective, open ended and inconclusive (Denzin, 1989; Derrida, 1976). As Vidich and Lyman (2003) exclaim, interpretative inquiry is an ambitious project with many provisos; the ability of the researcher to assume an objective stance, detached from their own subjective interpretation and the discursive

constitution of their self. Medd (2002) argues that research involving human social systems is so easily limited by the researcher themselves, the questions they ask, their interests, their bias, can blinker them.

The quest for coherence is fraught; we cannot assume a commonality of meaning or understanding, a smile or a wink can be variously interpreted so how can we extrapolate this to the whole (Law and Urry 2004). What I interpret as a pattern is a personal and retrospective snapshot which may not exist tomorrow (Minichiello *et al*, 1995) so to employ such a strategy is defective and inadequate for a relativist CES where rules and patterns of behaviour are fractal and dynamic.

Derrida (1972) cautions us against searching for a clear window to an agent's inner life. Language is inherently instable; there is never a clear unambiguous statement. One can interpret, but language is not transparent, one can never really know how an 'author' wants us to interpret his/her work; interpretation can only ever be complex, tentative, suspicious and racked with doubt (Minichiello *et al*, 1995). Barthes (1963) insists that interpretation is subjectively tied to our own values, assumptions and preferences and this claim is illustrated in Barthes (1963) work, *Sur Racine* which demonstrates the incompatibility of interpretations by Goldmann, Mauran and Barthes of a Racinian tragedy and in Foucault's (1978) work *I, Pierre Riviere* (Davies, 2004). In the latter Foucault describes a *battle among discourses* where two conflicting arguments could be constructed from the same information. With these interpretative limitations explored I thus feel confident in dismissing the application of phenomenological and hermeneutic frameworks in this inquiry.

### **Researching on Shifting Sands – K- Pax**

Released from the shackles of objective and positivist science, I seek a methodology that can accommodate the social dynamics of the CES, that can reveal rich and abundant scenarios that harbour a multitude of meanings; any notion of 'real' in scientific terms is abstract (Burrell, 1998; Medd, 2002; Reissman, 1993); *Complexity raises questions about the real* (Medd, 2002: 79). As I clarified in Chapter three, attempts to model a complex human system is

mere pretence as precision is not possible nor consistent in an open and co-evolving system that displays unpredictable and fractal patterns of interaction (Richardson, 2005). Reality is partial, shifting and co-created and change is the normal state of affairs (Bauman and May, 2001; Derrida, 1976; Foucault, 1972; Sarup, 1988); *the instability of a social reality must be studied from within the same instability* (Dumont Jr. 2008:14). As a researcher self located in a CES this signifies that I can never have inclusive, unbiased and unambiguous information to establish any absolute truths about the context of my study (Lyotard, 1984) and requires that any methodological approach is interpretative (Alvesson and Deetz, 2000). Ontologically the ‘object’ of my research is a *becoming* (Denzin and Lincoln, 2003; Sanders, 1998; Prigogine, 1997) subject, continually under construction.

It is contested that researching complex human systems requires that substantive rationality be abandoned altogether (Byrne, 1998; Wallerstein, 1996), but Byrne (1998) argues that I must consider the adequacy of relating conclusions to any community as a whole. Checkland (1981) explains that attempts to use scientific methodology to find high reliability and laws to predict and engineer the extreme behaviour of human systems is the reason why management science has had limited success. The disregard of agency, subjectivity and context assumes change simply acts upon agents, reducing agents to structurally and determined entities (Davies and Thomas, 2000). Levi-Strauss (1966) stresses that methodological analysis “*cannot be carried out according to Cartesian principles of breaking down the difficulty into many parts as may be necessary for finding the solution. There is no real end to methodological analysis, no hidden unity to be grasped*” and that any methodological interpretation becomes *a phenomenon of imagination*, a means of endowing a concept with synthetic form (Levi-Strauss, 1966:5-6).

Kuhn (1977) contends that divergent thinking in research is not a new concept and claims that; “*gigantic divergent episodes lie at the core of most significant episodes in scientific development*” (1977:226) where novelty of inquiry emerges from existing paradigms because the scientific community cannot and does not exist in isolation; paradigms are emergent and temporal inter-subjective

constructs. The Gulbenkian Commission on the Restructuring of the Social Sciences (Wallerstein, 1996) recommends that the dynamics of non-equilibria and non linearity be the model for social sciences and contends that humanity should not be conceived through a mechanistic lens, but as active and creative.

Feyerband (1975) explains that relativism appreciates that no single method can grasp the subtle variations in human and thus every methodological strategy has something to offer, there is no hierarchical ordination; *Methodological pluralism* (Gill and Johnson, 1991), and the *making of multiple worlds* (Law and Urry, 2004: 397) whilst it may unsettle the management research academe, seeks to enrich not undermine their understanding of social and organisational phenomena. Methodological plurality is encapsulated in the concept of *bricolage*, (Kincheloe and McLaren 2005:316) where all knowledge and interpretation is a matter of perspective, viewed by different researchers no view will be the same, but all will be valid. In our fractal and evolving existence any totalising description is conditional and inconclusive; simply a manifestation of *the culture and language that constructed it, inseparable from the historical dynamic that shapes it* (Kincheloe and McLaren, 2005: 316) Richardson and Pierre (2005) consider this is a prismatic approach to research, where knowledge reflects a spectrum of colours which vary with the angle of repose. Knowledge must be thought of as fragments of mosaic, each piece contributing to a total picture.

### Critical Inquiry - *The Great Escape*

*“Face piles of trials with smiles, it riles them to believe that you perceive the web they weave... keep on thinking free”*

(Edge, 1969)

The central tenet of critical and post-structural inquiry is the critique of power and the way in which the self is constituted by the discursive claims of discourse. It is a mode of inquiry that acknowledges that political, economic and social forces underpin every truth claim (Alvesson and Deetz, 2000) and intends to stimulate new ways of thinking to create a richer and more varied picture of organisational phenomena and by doing so attempts to disrupt the status quo by revealing and addressing political injustice (Kincheloe and McLaren, 2005).



Hence critical inquiry becomes an essential dimension of my methodological framework with which to explore the context and reveal the competing discursive constructs that constitute the NHS.

### **The Logic of Critical Inquiry- *Good Morning Vietnam***

Critical inquiry, grounded in thoughts of Kant, (1929) disputes the notion of epistemological reasoning and rationality, arguing that reasoning is as logical as *hearsay* in its neglect of subjective interpretation and reflection (Davis, 2004; Hospurs, 1997; Sarup, 1988). Critical studies evolved from Kant's claim, not into a unified or coherent intellectual movement, (Kincheloe and McLaren, 2003; Learmonth, 2004; 2005) but a connected set of debates (Parker, 2002) that represent a key epistemological shift that questions the status quo (Kincheloe and McLaren, 2003); an *ethical project with laudable aims* (Holland, 2004), an *anti-performative stance* (Learmonth, 2004:2) challenging, disrupting but precariously positioned against the dominance of mainstream research (Learmonth, 2004). The importance of critical inquiry for studying a CES is that it refuses to allow confounding factors, such as subjective interpretation and emotion to be disregarded from social situations (Denzin and Lincoln, 2003; Gray 1996).

Pertinent for this research, is that critical inquiry recognises the inequality wrought through the strategic ordering of knowledge and language and seeks to promote a democratic, ethical and emancipatory voice (Alvesson and Deetz, 2000; Billing, 2000; Burrell, 2001; Holland, 2004). A central aspect of critical inquiry is *critical humility* (Kincheloe and McLaren, 2005); an ethical dimension to research, that attempts to address the way we are unconsciously 'trapped' in modernist discourse engendering the need to explore and challenge the assumptive notions of freedom and democracy in the Western world in order to reveal how knowledge is constrained and that competing power interests constitute and acculturate the oppressive-productive nature of human existence (Denzin and Lincoln, 2005; Kincheloe and McLaren, 2003). It is thought that by provoking awareness the aim is not to determine a theory of reality, or to determine laws to engineer social behaviour, but to stimulate emancipatory strategies, allowing society to transform itself, to intervene on issues of power,

values and justice (Fournier and Grey, 2000; Holland, 2004; Kincheloe and McLaren, 2003; Sotirin and Tyrell, 1998; Tuhiwai-Smith, 2005).

*Critical Theory* is attributed to the Institute of Social Research at Frankfurt University and reflects a structuralist and pro-Marxist trope, appealing to the notion of ideology and its allegiance with structural linguistics and thus is not an appropriate way forward for a post-structural perspective of power. However critical inquiry can also entertain a post-structural position, denying the fixity or unification of discourse and epistemically re-positioning the analysis of power at an inter-subjective level (Guba and Lincoln, 2005). Guba and Lincoln (2005) consider that post-structural inquiry is the response to the realisation of the *richness of the mental, social, psychological and linguistic worlds that all individuals and social groups create and constantly re-create and co-create* (Guba and Lincoln, 2005: 204); there is no definitive account, only an inter-subjective perspective epitomising the diverse, indeterminate and co-evolutionary principles of the CES.

### **Critical Approaches in Management Research - *Chance of a Lifetime***

Historically, critical inquiry has focused largely on ethnicity, gender, class and sexuality and although it is held in regard in the discipline of organisation studies, its application in the overlapping discipline of management is surprisingly marginalised in comparison to the mainstream positivist approaches (Carter, 2008; Gray 1996; Kincheloe and McLaren, 2003). However it is becoming more recognised and validated within the management academe to encourage the progress of knowledge through meaningful debate and transforming the research *of* management to the research *for* management (Burrell, 2001; Alvesson and Wilmott, 1996; Alvesson and Deetz 2000; Carter, 2008; Fournier and Grey, 2000; Parker, 2002) Its objective is to work progressively with management theorists to reflect on how organisations, like Semco, in Brazil, (Semler, 1994, 2003) have been transformed (Parker, 2002).

Although I do not necessarily concur with some of the analytical processes used and the tendency to conclude with reductionist and generalised statements the critical paradigm is becoming more widespread in public sector research. In health and social care contexts, it has been employed to explore how

managerialism is distracting clinical discourse towards managerial goals in a nursing context (Brooks and McDonald, 2000; Hau, 2004), to analyse the discursive statements and practice of nurses (Hegney, 1998; Kim, 1999; Sambrook; 2006; Street, 1992) and to explore domination (Thompson, 1987), empowerment (Fulton, 1997) and violence (Varcoe, 1996) in a nursing context and to reveal the clash of clinical and managerial discourses in clinical leaders (Young, 2000).

At strategic levels this critical mode explores the power relations between doctors and managers (Greener, 2004), the privilege of managerialist values in managers discussions of equal opportunity policy (Hamilton, 2004), the effect of managerialism on organisational trust (Gilbert, 2005), the uncritical approach to the dominance of evidence in evidence-based medicine (Harrison, 1998; McLaughlin, 2004) and on the impact of performance management and surveillance techniques on staff anxiety (Lacey, 2006; Sarra, 2006).

In business contexts critical inquiry has revealed that accounting is not a neutral, technical discipline but instead a socially constructed discourse of power/knowledge (Carter, 2008) and demonstrates that the discursive practice of managers can contradict an organisation's allegiance to its adoption of the Learning Organisation metaphor (Akella, 2003). In a study of management and leadership critical inquiry reveals the asymmetry of gender relations in management discourse (Alvesson and Wilmott, 1996; Calas and Smircich, 1991; Collison and Hearn, 1996; Ford, 2004; Oseen, 1997, Yancy, 2002), the ways in which discourse can reinforce the saliency of managerial control through oppressive mechanisms of power (Deetz 1992; Harrison, Small and Baker, 1995; Learmonth, 2006; McDonald, 2004; Nord and Jermier, 1992) and reveals how status and authority are powerful tools in defining discursive reality (Rose, 1999b).

Whereas mainstream management research is been criticised for being overly concerned with purposive action, the sermon that the critical approach preaches frequently appears at the other end of the spectrum, as one of anti-modernism and revolution, and for the world of business and management projecting this message would be potentially futile. However, Learmonth (2004) believes that

critical inquiry in the NHS has had the courage to break the silence, encouraging the noise to break through. Learmonth's use of the metaphor *noise* is particularly relevant for me as it reflects the diversity of voice that both management research and managerialism attempts to suppress and elaborates how critical inquiry can engage the polyphonic voices of both researchers and their participants, providing a space in which to divulge their stories and experiences, stimulating a sense of liberation and genuine empowerment; the positive characteristics of power is released. Supporting Edge's (1969) leading quote, Foucault (1994) claims, critical exploration reveals; "*how we are trapped by the way things are, but by revealing this it enables us to transform them*" (Foucault, 1994: 295).

### **Devising a Discursive Analytical Approach - *What Lies Beneath***

In positing a discursively constituted reality and a relativist epistemological position my methodological approach is driven towards discourse and discourse analysis to provide a critical analytical framework through which I can reflect at the inter-subjective level of a social system. My previous chapters reveal how statements of discourse reinforce a particular image of reality and the way in which this image can be legitimised or resisted at a the micro-level and the next stage of this thesis is to explore the extent to which this reality is impacting on an agent's discursive practice within my context; "*Each discourse provides an orientation to organisations, a way of constituting people and events and a way of reporting on them*" (Deetz, 1996:198).

Discourse analysis is a generic term that encompasses six methods of deconstruction, *ethnomethodological conversation analysis*, *interactional sociolinguistics* and the *ethnography of communication*, *discursive psychology*, *critical discourse analysis and critical linguistics*, *Foucauldian* research and *Bakhtinian* research (Wetherall, Yates and Taylor, 2001) although Graham (2005) argues that there is no such thing as Foucauldian discourse analysis and that Foucault's post-structural stance would preclude any prescriptive methodology. However, it is essential, at the outset that I briefly delineate between discourse analysis and conversation analysis and explain why the latter is unsuitable, even though these terms can be applied synonymously by some researchers (Ricoeur, 1981). Conversation analysis is premised on a stable

linguistic framework as portrayed by Austin and Searle (Howarth, 2000; Williams, 1999) to analyse concrete speech situations located at a specific point in space and time. With regard to my epistemic frame of reference, I have asserted that the ability to negotiate absolute meaning is futile. I am, as Cortazzi (1993) suggests unable to access all the meaning in my respondent's head and several exchanges would not necessarily consequence in any accurate interpretation.

In contrast, discourse analysis explores *the language above the sentence* (Stubbs, 1983:1) and does not seek to reduce social phenomena to underlying causes (Howarth, 2000) but is a *way of viewing social life* (Fairclough, 2003), a forensic exploration and deconstruction of the discursive context that constitutes the self (Jaworski and Coupland, 1999) and where discourse is not a mirror on reality but a vehicle for disseminating and shaping socio-political norms (Brenneis, 1996). Miller and Crabtree (2008) liken this to the clinical consultation process in medicine where the doctor must look beyond the presenting concern to an underlying issue in the patient's life.

Although not totally remiss in their notions, my post-structural inter-subjective ontology requires me to dismiss the constructionist macro-level approaches of phenomenology, socio-linguistic, Bakhtinian semiotic and *gestalt*/psychological approaches as all present a realist, determinist and modernist quest to document the existence of universal truths and structures about behavioural processes (Dumont Jr. 2008; Hirschkop and Shepherd, 2001; Parker, 1992; Wengraf, 2001; Williams, 1999) and perpetuate the dialecticism between discursive practice and the priori social structure that frames activity (Howarth, 2000; Wodak, 1997). Whilst they may fit my needs critically none fulfil them at the epistemic level as they consider discourse is auto-determining and closed (Williams, 1999).

### **Post-structural Discursive Exploration - *The Return of the Pink Panther***

Discursive practice and the (re)formation of discursive statements is an inter-discursive phenomenon that draws from a plurality of diverse discourses associated with many fields. To reveal the extent of inter-discursivity within our

context, Candlin and Maley, (1997) suggest that Foucauldian methodology, or as Foucault prefers, *instrument of analysis* (Williams, 1999) is indispensable to provide a catalyst for critically thinking about organisational practice, the unifying concepts that constitute the habitus and domains of knowledge that interact and perturb.

A Foucauldian framework provides the micro-level analysis required to research a CES, deifying the organisation, emphasising singularity (Burrell, 1998) and demonstrating the heterogeneous, polyphonic, episodic and unpredictable nature of the organisation and the emic nature of knowledge. Burrell (1998) explains how findings; “*preserve the multiplicity of factors that describe organisational life, emphasising the complexity, contingency and fragility of organisations as transitory manifestations of relations of dominance-subordination and as a mere embodiment of underlying relations of force*” (1998: 24).

Foucault has been well accepted into the field of organisation studies where his thoughts have contributed to understanding the technologies of power in human resource management, nursing practices and accountancy and in understanding organisational surveillance (Carter, 2008; Hegney, 1998). Foucault’s work has been describes as *quasi* (McKinlay and Starkey, 1988) *semi-structuralist* and *post-hermeneutical* (Dreyfus and Rabinow, 1986) but echoes phenomenology only in its object of interest; the discursive strategies that inform practice (Alvesson and Deetz, 2000; Holstein and Gubrium, 2005). Foucault transcends structuralism by transforming phenomenology into a *becoming* (Denzin and Lincoln, 2003; Sanders, 1998; Prigogine, 1997) orientation suitable for an evolving context, through an “*analytic sensitivity to the discursive opportunities and possibilities at work, in talk and social interaction, but without making it necessary to take these up as external template for the everyday production of social order*” (Holstein and Gubrium, 2005: 492).

Allowing me to work within my theoretical framework, Foucauldian (1972) discourse analysis allows me to search out the strategic exercise of knowledge, privileged relations of power, the sites of legitimacy, struggle and resistance and how *différance* is formulated and reinforced in the discursive space between

conflicting discourse. Guba and Lincoln (2003) contend that the post-structural attempts to represent the contradictions and truth of human experience and show how agents cope with the “*external verities of human existence and the daily irritations and tragedies of living that existence*” (2003:285).

Butler (1990) although proposing a structuralist ontology of self allows Foucault a prominent place in her thinking and suggests I seek the *performativity* of a text, a term denoting a different aetiology to Lyotard’s (1984) application; “*The reiterative power of discourse to produce the phenomena that it regulates and constrains.*” (Butler, 1990: 25). In her deliberations about the gendered self, Butler contends that performance re-constitutes the self, but her notion of performance resonates with Foucault’s concept of discursive practice rather representing Goffman’s thoughts of conscious acting; it is an impossible task to ascertain the conscious and unconscious elements, even though one overshadows the other.

In deconstructing the interview I do not wish to distinguish right from wrong, but aim to expose the dominating statements that construct the object of health care reality from a particular perspective, the positioning of the authorities of delimitation and the extent to which diverse discourses are tied together through grids of specification. Of importance to this thesis is to understand the extent to which managerialism is transforming patterns of discursive practice, driving or perturbing naturalistic and self-organising behaviour (Dreyfus and Rabinow, 1986; Mills, 2003) or adversely influencing the adaptive tension required for spontaneous transformation.

With regard to my context where moral and ethical commitment to patients is expectantly obligatory, my analysis also makes reference to a concept Fletcher (1999) employs in her study of female engineers, *relational practice* (1999:48) and in particular, Fletcher’s notion of *preserving* behaviour described as; *preserving the project through task accomplishment* (1999:48) and *self-achieving behaviour*, described as; *empowering self to achieve project goals* (1999:48) descriptions that imply a moral aspect of behaviour, *doing what needs to be done... minimising power relations...and putting up with procedures in*

*order to help the project.* (1999:49). It is a concept that echoes the claims of a commitment based ideology in its phraseology I agree, but is apt for describing how agents need to support their practices in the face of a dominant claim.

### Post-structural Reflexivity and Re-framing Validity - *Little Voice*

*“Famous scientists are allowed to say how their basic insights were informed by intuition, but the rest of us have to pretend that we are basing everything on hard fact.”*

(Brockman, 1997: 199)

In light of my extensive experience of the context, I bring to this research a high degree of situated knowledge and as such I intentionally locate myself within my research, reflexive and comparative, emphasising the interdependency between my self and the participant other, blurring the objective epistemic boundary between my self and my participants (Olesen, 2005). I realise that, in orthodox research, subjectivity is regarded as pejorative (Teale et al, 2003), but in critical research every perspective and interpretation of reality is unique and valid, even if this posture harbours as much blindness as insight (McCracken, 1988). However, introducing the element of situated knowledge impacts on the notion of validity and requires that I re-conceptualise the scientific understanding of this abstract notion.

### **The Epistemic Imperative of Reflexivity - *Alice Through the Looking Glass***

Reflexivity is an elusive concept that encompasses notions of introspection, of being conscious of our self and centering analysis critically upon ones self within a context (Lipp, 2007). The epistemological concern of reflexivity is the relationship between researcher, researched and context and the way knowledge is produced from this interaction (Harley, Hardy and Alvesson, 2008; Kincheloe and McLaren, 2005; Lipp 2007). As I cannot escape from the unstable discourses of life that constitute the mobility of my self (Dumont Jr. 2008) my omnipresence contends that my interpretation can only represent a provisional, partial and tentative account bound within my own experiences and legitimised knowledge.



Reflexivity is influenced by the view that knowledge is always tied to a particular perspective of reality that carries political privileges and which need to be interrogated (Harley, Hardy and Alvesson, 2008). This prior claim that that no agent can provide an accurate or unbiased account of his or her actions and intentions provokes a crisis of representation by acknowledging that all knowledge is to some degree is local and situated, but it is an epistemological position that liberates the researcher from the constraints of scientific representation (Richardson and Pierre, 2005).

Reflexivity places an ethical responsibility on me as researcher to raise voices without distortion or disrespect (Kincheloe and McLaren, 2005; Olesen, 2005). If researchers are unable to directly capture the lived experiences of agents, then my interpretation is merely a subjective representation (Chase, 2005; Denzin and Lincoln, 2003; Flyvberg, 2001). Whereas the constructivist attempts to remove this subjectivity, the object' of the research, discursive practice, rests at the inter-subjective level where the researcher and respondent co-create understandings of the social world; the researcher assumes a position of both knower and teller; the boundaries blur (Davies, 1999; Denzin and Lincoln, 2003; Richardson and Pierre, 2005).

As I am historically constituted by my experiences of a secondary care context my thoughts and the reality expressed are predisposed in a way that reflects my self. My account of the findings cannot be separated from myself as author of that account, but recognising my subjective co-participation does enable me to bring my voice to the findings. This being the case, it is vital that, as a researcher, I am introspective and explore my own standpoint and emotions to reflect on how I may guide or shape the findings (Kincheloe and McLaren, 2003; 2005) as my questions and inferences *create disturbance* in the relations of power (Holman-Jones, 2005).

Calloway (1992) and Altheide and Johnson (1998) contend that reflexive methodology it is becoming more acceptable and the crisis of legitimation wrought is only of concern if the traditional criteria for evaluating and exploring data are applied (Denzin and Lincoln, 2003). Altheide and Johnson (1998) argue that the expression of oneself in the research is a powerful resource in

understanding the other, although I feel I can invert this statement as, it is the expressions of others that can allow me to understand my self: *ethnographic writing not only expresses the voices of others, it also gives a privileged position to the researcher perspective, place and motivation for engaging in the study* (Altheide and Johnson 1998: 293).

In an interactive mode of inquiry, even if one party remains silent, reflexivity accepts that both the researcher and respondent approach each other with individual biographies, with distinct sets of experiences and expectations and whilst I strive to find meaning in the world of another, our realities are never identical (Bauman and May, 2001). Luhmann's (1998) research on love, contend that all of us have a particular opinion that we want others to accept as valid. He believes that finding a willing partner who is willing to listen and empathise lowers the threshold on what they consider is relevant and worthwhile and is the way that agents re-constitute their self, their idealistic images, joys and miseries (Bauman and May, 2001).

### **Re-conceptualising Validity in Reflexive Research – *Dances With Wolves***

The notion of reflexivity lies at the opposite end of the spectrum from the convention of objectivity, dismissing science's treasured notions of validity, reliability and generalisability and as such the question must be asked about how reflexive methods can be evaluated (Denzin and Lincoln, 2003). It is understandable why critics argue that reflexivity can easily be perceived as a *masquerade for transparency, a self-flagellating defence against criticism...rather than offering a reasonably lucid and decently honest statement of authorial position* (Grey and Sinclair, 2006: 447). Csarnaiwska (1998) responds to the critique by stating that reliability, in terms of repeatability with any accuracy is fruitless in social contexts and argues that similar results obscure the fact that it is research practices that tend to conform to the dominant rules of knowledge production. The insufficiency of language in describing respondents' experiences or in my authoring further exacerbates this dilemma (Butler, 1990; Lather, 1991; 1993).

In resolution, Schwandt (1996) believes validity should now be characterised by *aesthetic, prudential and moral considerations* (1996:68) the engagement of moral critique of human judgement. Guba (1981) adds that the trustworthiness of employing a methodological approach that encourages multiple voices and participatory methods claims authenticity by respecting the value of transactional knowledge and its ability to acknowledge one's presence in the field, will heighten rather than destroy validity, accepting that there is no one voice and that the researcher cannot claim any final authority. Flyvberg (2001) contends that Foucauldian approach to knowledge production is eminently valid in its phronetic quest to reveal the relationship between power, 'modernist ideals' and truth, where knowledge that does not fit the 'modernist ideal' is marginalised.

### **Exploring the Author's Habitus - *Basic Instinct***

Post-structurally positioning my self within this inquiry requires that I scrutinise my self before I interpret my findings through the voices of others (Vidich and Lyman, 2003). In the least my choice of the subject area and context implies personal implications, but it is my profound emotive involvement that is integral to this thesis; the personal becomes political (Holman-Jones, 2005). Behind every researcher is a personal biography, a montage of dispositions, experiences and prejudices that shadow the habitus, complete with diverse ontological perspectives that inscribe themselves upon their dominant episteme and methodology and which consequently impact on their way of thinking, interpreting and representing the context (Denzin and Lincoln, 2003; May, 2001). My thoughts and observations are filtered through the norms and strictures of my self.

My earlier chapters explored three major domains within my context and now I must add my 'self' as another discursive field that shapes the research process and thus the reality. My personal hexis is an historical concept of characteristics that has consciously and unconsciously emerged since childhood. My self sits within a discursive space as a complex and fluid pastiche of conflicting representations, not prismatic, but like an 'aurora borealis' of shifting hues where 'identities' like colours are distinguishable, but are constantly interacting, student, wife, leader, follower, confidante, pharmacist, none of which are stable

and none of which can be erased from the 'self' or the findings presented in this thesis. My self is bound to multifarious constructs that continually vie for my attention but whether my subsequent action meets or breaches the referential expectation of each normative discourse is debatable and no doubt varies according to my needs, desires and the anxieties engendered by others.

As a pharmacist my background in the life sciences concurs with the functional and cybernetic attributes of the genome and I consider that the genomic *raison d'être* is to sustain the reproduction of one's own DNA; I am sure there are those who would disagree but I believe that any life, human or otherwise, is governed this basic instinct. I also sincerely believe that the body has an amazing capacity to maintain its own functioning, it is after all a CAS, and I consider that medical science, certainly in our Westernised society, is in some ways, by removing 'system' perturbation, is preventing the course of natural evolutionary processes. Of course, it is generally not accepted by contemporary society, myself included, that people should suffer for this gallant cause, so medical science continues to strive to facilitate the nebulous concepts of health and well-being, whatever society and politics appears to throw at it. You may note that this latter statement is true to my self in its implication of my disquiet of political discourse and its impact on health care.

However, I consider this realist ontology ends at the genotype and this is where discursive relativism begins, where human beings employ the notions of love, power, status and money as convoluted tools to achieve a suitable mate, although the subjective interpretation of these commodities is extensive and variable. Sounds fun? Gell-Mann (1994) supports my thinking, by suggesting that the genotype is structured to allow for a degree of adaptive behaviour. Hence the phenotype is influenced by a huge variety of random circumstances, it is adaptive and open to the impact of discursive constructions around which we are compelled to shape our lives as we strive to fulfil our desires and extinguish our anxieties.

Whilst I am possibly caught within them, my recent academic studies now make me cautious about the empiricist beliefs of realist knowledge and universalistic

concepts and the attraction of a relativist ontology lies with my acceptance of the plurality and eccentricity of folk, although in retrospect it is a tolerance manifest through age. My studies have also opened my eyes, allowing me to perceive and challenge those who have occupied a privileged position in dominating our knowledge and therefore in structuring our understanding of life and closing our mind to alternative discourses.

The dispositional thoughts of Bourdieu similarly stir my awareness, the unconscious becomes conscious and I can now understand how dominant social discourses have influenced my pathway through life. In retrospect, my formative years experienced many conflicting discourses that concurrently constrained me within parental expectations and yet constantly pushed me beyond these expectations. Not that I remember expectations, parental or otherwise, as particularly evident, but I was frequently aware when they were breached, especially the anguish caused by my leaving home to go to university. To try and recollect how and which discourses were dominant in the constitution of my personal hexis is nigh impossible and an irrelevance as the hexis is a becoming and fluid phenomenon, constantly engendered throughout life and yet I can understand that particular moral, ethical and social dispositions remain true to my upbringing and believe they may create the semiotic drive that Kristeva (Sarup, 1988) describes.

Within my recent experiences of secondary care I now recognise how powerful organisational discourses are very persuasive in re-defining reality, almost veering to an extreme where I see the 'hidden agendas' of others in all interventions, even though their practice may be unconscious practice, rather than conscious malicious strategising. However, several colleagues and I confronted the latter where any challenge to the truth, however meek or evidenced, was met with a corporate solidarity that defied any act of resistive power. Hence I can see the relevance of Bourdieu's comments on status, especially the boundaries that others create, and which I experienced, to exclude, differentiate and marginalise. To say this experience removed adaptive tension is a modest interpretation of the situation and as a consequence the trajectory of my career, if not my whole life, has massively changed. I continue

to breach my own expectations, but cannot reconcile the dismay and sorrow that those circumstances wrought.

As to my choice of a career in pharmacy, I do not think it was driven by any compassionate need to help mankind, I must admit, but because of my passion for chemistry and biology. Returning to Bourdieu's dispositional theorem, it may explain that I entered acute care, seeing this as a more prestigious position, even though the salary did not reflect its status, it was certainly more intellectually challenging than other options. Any compassionate tendencies have not necessarily come from the normative logic of the field, but from the death of my father at a relatively early age and in coping with the deteriorating health of my mother; until then I think my semiotic needs were to a large extent, consumer driven, but I really can't recollect, I expect I flowed with the societal currents of the time.

Returning to my recent experience in acute healthcare I now believe that an agent can develop a tolerance of what is acceptable in the field and whereas this leads to some agents silencing their concerns in response to relations of power, others act and I was in the latter domain. So, I consider that of late, my life has encountered a discontinuity, a change in tolerance, the refusal to suppress my ethical disposition in the face of incongruent values and in many ways the analytics of Foucault (1972, 1980a) and Bourdieu (1991) have contributed to my realisation of the frailty of oppositional concepts, where, for instance, dominance requires an agent's acceptance of subordination and that leaders cannot be leaders without followers. It does not make life any less frustrating, but does motivate me in the direction of critical inquiry.

Hence, the advocatory and moral overtone of this inquiry is based on my belief that some agents attempt to control others through discursive strategies that differentiate between agents, whether overtly or covertly, and statements that are premised on a domain of constrained knowledge with the aim of bringing closure to intellectual thinking; *regimes of truth* (Foucault, 1980a; Kincheloe and McLaren, 2005) It is highly reflective of Bourdieu's (1991) belief that agent action is the ultimate acceptance of their position and explains how easily one can feel powerless and alienated in the face of opposition.

With other aspects of Bourdieu's (1991) work I am less comfortable. His theory relating to an agent's overwhelming desire to access symbolic capital may reflect a notable part of human existence and a route to power, status and DNA replication, but I cannot remember symbolic capital ever being high on my personal agenda. Bourdieu, of course, would argue that this due to my 'hexal' acceptance of my status or position, but this is somewhat simplistic and one that I cannot necessarily relate to; that life is a continual struggle to preserve and improve position and status within a particular field. Maybe I am wrong, but for me, at the heart of human existence is the need to be wanted and the want to be needed and when these elements disappear, your whole world begins to collapse, and is something I can relate to.

### Negotiating a Method – *Brief Encounter*

*“Robots are not people. Mechanically they are more perfect than we are, they have an astounding intellectual capacity, but they have no soul”*

(Čapek, 1923:6)

The 'object' of the study in my inquiry is not the factual experience of agents, *per se*; but an exploration of the extent to which managerialist discourse is legitimised, tolerated or resisted by agents and the impact this inter-discursivity has on their practice. Therefore, I require a method of data collection that accommodates the inter-subjective and temporal ontology and relativist epistemology premised by my theoretical framework and one that provides the substrate data for discursive analysis. As a complexity thinker I am also aware of the unpredictability of real life contexts and I need a technique that Czarniawska (1998) incorporates artfulness with the instrumentality and a style that can be inspired by the context as it emerges. In retrospect, Czarniawska's advice is worthy as I found respondents do not respond as expected and I needed to intuitively adapt to the diverse situations with which I was presented.

### **Accommodating Contextual Sensitivities – *Don't Look Now***

Exploring the micro- perspective requires that I interact with my participants and their context, listening and observing and thus a multi-method approach

would provide the optimal approach (Minichello et al, 1995). Ethnographic observation focuses and records the way in which people act, interact and collaborate in observable and regular ways (Fletcher, 1999, Gill and Johnson, 1991) and a follow up interview can provide the context dimensions that motivate particular behaviours (Fletcher, 1999).

Joint approaches of observation and interview have been used successfully in NHS research. McDonald (2004) employed interactive interviewing and a participatory observational approach in her study of a primary care healthcare organisation, to explore the tensions between leadership styles and Hau (2004) used the same techniques in secondary care to investigate how managerialism impacted on nursing priorities. However, as I do not work in the context this participatory technique is not accessible.

Structured observation is an ideal technique for exploring discursive practice and to gather contextually specific and multi-voiced accounts of socio-political interaction (Fletcher, 1999) and can generate data about how people actually act, rather than how they profess to act. Jacques' (1992) used this technique in her observation of female nurses to produce data as enacted text, but the use of this metaphor unnerves me; as I observe I participate and thus affect the outcome; I am an intruder (Chase, 2005) so would the observed merely be 'enacting' a performance to compliment my presence, what they think they should do or say; would I be able to observe genuine discursive practice through observation (Saunders, Lewis and Thornhill, 2007). Besides, my description could never actually match what occurred and my subjectivity would preclude any accurate observation through assumption (Nisbet, 1977; Taylor and Bogdan, 1984).

However, I am sensitive that at the outset that I employ a technique that fits my healthcare context; a data collection model that, as McCracken (1988) advises, respects the hectic and unpredictable lives of my participants, that is relatively unobtrusive and would optimise the valuable time that they could offer me, but also one that can generate a rich and subjective account of health care lives. Although ethnographic observation in management has been undertaken in



many sectors (Gill and Johnson, 1991) I have two main reservations in applying this technique in clinical contexts for practical reasons.

(Un)fortunately, as a healthcare professional I have some subjective understanding of how agents may perceive observatory techniques. Scientific research is commonplace in the NHS and qualitative inquiry relatively unknown and may be considered as trivial. A second consideration is that of access, as an observatory method within the clinical environment is highly intrusive and any ‘freedom to roam’ may impinge on patient confidentiality, dignity and data protection. Furthermore I sense an observatory technique could potentially increase the risk to patients by distracting participants from their work. In the current political climate, secondary care is subject to a high degree of scrutiny and regulation and observational methods may generate apprehension and anxiety in its subjects, rather than the climate of openness and trust that I wish to facilitate.

By ruling out the appropriateness of ethnographic observation and the access to written texts, although one did emerge in the course of my research, face-to-face interviews are chosen as my primary and interactive mode of inquiry. Mitleton-Kelly (2003b) contends that, for studying a CES, the method should accommodate the evolving and co-evolving characteristics by tracking changes over time and by generating enquiry about the wider system. Mitleton-Kelly (2003b) considers that employing an interview technique that can encourage data for ‘narrative’ analysis can identify the patterning and depict commonalities within a fractal representation of the organisation, where each agent offers differing, but overlapping, perspectives.

Discourse analysis requires the generation of richly detailed narratives, stories and personal biographies with which to explore and deconstruct discursive practice, the respondent’s self and the construction of difference (Chase, 2005; McCracken, 1988; Reissman, 1993; Wengraf, 2001); to glimpse the categories and logic by which he or she sees the world (McCracken, 1988:9). With regard to my vast experience of the context it can, as Denzin (1989) suggests, allow me

to immerse my self within the context and present an integrated and multi-voiced synthesis of knowledge.

Baskin (2008; 2007) offers a novel perspective of a human CAS as a *storied space* (2008:1) explaining that *we live in a story-constructed world that each of us are co-creating from moment to moment* (Baskin, 2007:1). Baskin considers that humans use stories as a way of explaining their perceptions of the world and that the storytelling process is used to adapt that world. Baskin (2007) contends that every story is partial and subjective, only existing at the micro-level and never presenting any notion of the whole truth, but argues that each story contributes, conflicting and legitimising perspectives through feedback to engender a dominant schema, the discursive unity, that becomes the attractor state for a particular network.

The in-depth and open interview has been successfully employed in isolation to generate rich data in the NHS (Brooks and McDonald, 2000; Hegney, 1998; Sambrook, 2006) and in business settings (Akella, 2003; Rose, 1999b) especially where observation would have been insensitive (Bowers, 1987) or impossible (Brown and Minichello, 1994). To support the interview process secondary data was collected in the form of the minutes of the Trust Board meetings.

The meeting of the Trust Board is unique in providing a monthly coming together of the key strategic representatives of secondary health care and their partner organisations, where discussions and decisions would be informed and potentially influenced by dominant discourse. I consider that exploring the minutes would highlight the strategic imperatives of the Trust and potentially unmask the surfaces of emergence from which certain issues arise and enter the discursive practice of both senior managers and clinicians. The minutes are publically available on the Trust website and thus avoided any possible breaches of the Data Protection Act (1998). The minutes for the six months prior to the interviews and the six months of the interviews (twelve months in total) were explored after the interview phase had completed to avoid any influence on the researcher self.

### **The Nature of Stories - *Pulp Fiction***

Before I continue to discuss the advantages of using stories and narratives in discourse analysis, ambiguity and lack clarity surround the terms *narrative* and *story* (Agar, 2005; Bertaux, 1981; Minichiello et al, 1995; Polkington, 1995; Reissman, 1993). Many researchers treat the terms ‘life history’, ‘informal narrative’, ‘oral history’ and ‘life story’ as synonymous as all have a common focus; the experiences of the narrator (Atkinson, 1998; Bloom and Munro, 1995; Denzin and Lincoln, 2003). They are stories that examine life or a segment of life from the agentic perspective, *self stories* (Denzin, 1989). For purposes of clarity however I propose to adopt Boje’s (2001a) differentiation as an aide to my analysis.

Boje (2001a) states that the “*story is an account of incidents or events, but the narrative comes after and adds plot and coherence to the story*” (2001:1). Boje uses the word plot to reflect Csarniawska’s application, *to bring them [the story] to a meaningful whole* (2001a: 2). Boje (2006b) describes the story as holographic, embedded with different facets, and emphasises the fluid, ambiguous, multi-dimensional and emergent ontology of the story (Boje, 2001a), a notion that is fitting for a CES. Boje (2001a) considers stories as superficial; *nodes or links in a narrative network, mere architectural display* (Boje 2001a: 10) where the ensuing narrative provides a retrospective explanation for its telling; the fractal rules of behaviour that underlie the surface. So whilst the story defies deconstruction, it is the narrative that allows us to link the story with a particular discursive order.

As Boje (2001a; 2006b) suggests, stories are emergent events, not necessarily structured or chronological; storytelling is a never-ending process of sense-making; a search for meaning (Chase, 2005; Czsarniawska, 1998); a self-reflexive process, intricately bound with an agent’s self that muses over memories and interpolates the past, present and future (Atkinson, 1998; Frow, 1995; Kerby, 1991). Consciously or unconsciously, stories are potentially inaccurate and may bend the truth (Cheever, 1984; Cortazzi, 1993; Holloway and Jefferson, 2000) or *the truth may be wrapped in sheer fiction* (Kohli, 1981; 73); *something fashioned out of real and imagined events* (Denzin, 1989:41).

Respondents may initiate with a sincere and determinist ending, but unless they have a conscious and distinct strategic purpose, they frequently are, like the lives they reflect, open ended, inconclusive, ambiguous, biased, incoherent, subject to multiple interpretation and sensitive to context (Barry and Elmes, 1997; Boje, 2001, 2006; Czarniawska, 1998; Denzin, 1989; Holloway and Jefferson, 2000; Jones, 1996; Sthyre, 2004). This is not a limitation because even unconsciously stories are strategic events, their underlying narrative is conveying a political position, like a cinematic film script, they act as the auteur and the telling of their stories can re-write history and transform or confuse our sense of reality; there is a reason why a story is worth telling.

### **The Intricacy of the Story and Self - *True Lies***

Stories and their underlying narratives are interdependently coupled with an agent's discursive practice; discursive practice is recounted as a story and through this story the self is re-validated (Atkinson, 1998; Chase, 2005; Kristeva, 2003). Kristeva (Davis, 2004) considers that in the de-centred self, the 'subject' *endeavours to reassemble a sense of existence that it perceives as its own* (Davis, 2004:131) and that crucial in this process is the ability to construct and narrate stories. Kristeva (Davis, 2004) contends that storytelling implies *the existence of a community as it requires agents who act, witnesses to recount and audiences to listen and interpret and recount themselves* (Davis, 2004:133) and considers this can engender group cohesion even though stories are only subjectively interpreted. In many ways Kristeva's image echoes the way in which a network of agents interdependently negotiate and legitimise the rules of the field. However, what is important to recognise is that stories act as a strategic tool and are not an exact mirror of the world and must not be construed as such (Reissman, 1993).

Bruner (1986) adds that there is a distinct difference between life as lived and life as told as the latter is influenced by cultural conventions, the audience and the context; the narrator is not a free and autonomous self (Chase, 2005; Foucault, 1984b; Denzin, 1989). No agent, teller or author, can portray a free and accurate description of experience (Davies, 2004; Stein, 1960) they are the

*ventriloquist's dummy* (Minichiello et al, 1995) and no listener could grasp the emotion unless they have lived a similar experience (Davis, 2004). It may be that consciously changing the facts portrays that actions contravene an agent's personal hexis, norms of action or expected norms of action, but as a listener I cannot interpret this with any precision.

Derrida (1976) reminds me that all texts harbour multiple meanings. It must be remembered that stories are co-constructed between the narrator and the listener, even if the researcher is silent or interjection is minimal, their presence will impact on how a story is related, but Chase (2005) elaborates that it is not the specific event that is important, but the meaning that experience held for that agent. As a contextually sensitive event stories can be elevated or constrained in line with socially and culturally determined images (Eagleton, 1983). Agents may attempt to valorise, justify or even confess (Chase, 2005) and is demonstrated by Grima (1991) where stories of hardship and suffering in Pakistani women were connected with their need to promote a honourable image (Chase, 2005).

All stories are, in themselves, modes of unique action, a verbal form of discursive practice that draws on particular discourses to objectify a particular reality through statement of defence, confirmation or challenge (Bruner, 1986; Chase, 2005; Linstead, 1999; May, 2001). Baskin (2005) claims that; *"storytelling is a biological imperative...the way they can capture coherent perceptions of the unknowable and complex world"* (2005:32). The way agents describe an event or with whom they identify is a symbiotic relationship between action and self (Czarniawska, 1998; Holloway and Jefferson, 2000; Langellier, 1999; Kristeva, 2003).

Reality becomes objectified through telling (Ricouer, 1981) and thus this method of inquiry can reveal clues to an agent's self and one that re-constitutes the self of both researcher and respondent at the interface (Holman-Jones, 2005) as stories reinforce or transform their dominant norms and values; the story is a bridge between the self and 'society' (Kristeva, 2003). This 'revelation of self' is recognised in Foucault's (1977) explanation of the power of the confessional,

where the act of talking actively re-constitutes the self in reflection with socially determined subjectivities; the story is actively shaped around these societal norms, values and beliefs (Atkinson, 1998).

### **The Power Within Stories – *Being John Malkovich***

Stories and narratives frequently orientate around significant events, establishing a connection between the ordinary and exceptional (Bruner, 1990; Denzin, 1989; May, 2001), in particular, breaches of the ideal (Reissman, 1993). Stories are, therefore, expressed in ways to imply a particular opinion or standpoint (Chafe, 1980) that reflects the patterns of norms and disposition that constitute the habitus. Hence stories act as *narrative strategies* (Chase, 2005), strategic acts that reinforce a dominant narrative and can distort, marginalise and omit, revealing or disguising events within the constraints of their socio-political context (Atkinson, 1998; Holloway and Jefferson, 2000; McCracken, 1988). Each plays out its own hidden agenda (Brenneis, 1996), even though this may not be consciously employed by the narrator, but in post-structural inquiry we are aware how the unconscious can seep into the conscious although it will be impossible for a listener to identify the conscious need to relate some stories more than others. The power of language and status was disclosed in the previous chapter and it is now clear how the story is being employed, as Boje (2001) contends, as a superficial vehicle for the dissemination of narrative and their inherent power throughout the system. In reflecting Foucault's thought stories act as stabilising nodes of power in a relativist system and by doing so shape future discourse and thus perspectives of reality (Brenneis, 1996).

Boje's (2006a) meta-analysis of published storytelling literature recognises that stories are used instrumentally as strategies for change and influence, as a tool of hegemonic control (Boje, Luhman and Baack, 1999) to make strategy credible (Barry and Elmes, 1997) by adopting single voices or particular managerial privilege (Boje, 1991a; 1991b; 2006a; 2006b, Boje and Rosile, 2003; Bryant and Cox, 2004; Landrum, 2000; Van Maanen, 1991). The intricate linkage of stories and power is also reflected by post-structuralist feminists who perceive the world "*as a series of stories or texts that sustain the integration of power and oppression...constituting subjects in a determinist order*" (Olesen,

2005:246). As Foucault (1980) suggests; the weak are defined as the weak through their own statements. Therefore, I feel an interview technique that can generate stories and narratives is a suitable method to reveal the emergence of discursive dominance and closure and to reflect on the practices that provide value and significance for the respondent (Holloway and Jefferson, 2000; Knorr-Cetina, 1998).

### Structuring the Interview Process – *Back to the Future*

*“Interview? Don’t clamour for an interview. Instead search for an inner view”*

(Sri Sathya Baba, unknown)

For the purpose of this research I require an interview technique that can capture the richness and complexity of my respondent’s experiences of secondary care life and one that can elaborate the temporal ontology of the context through stories and narratives. It is essential that my method does not influence the data but invites agents to lead the direction of their interview in a way that enables me to reveal the historic constitution of their selves, the inter-discursivity of their accounts, the strategic constitution of their statements and the concepts of reality that they attempt to portray to their listener. This section also clarifies how the study population is recruited and the research governance and ethical expectations. I complete this section and chapter elaborating on my post-structural approach to representing my findings in a way that raises the voices of both my respondents and myself as author.

### **The Biographical Interview Method – *The Life of Brian***

A lightly structured interview that has minimal researcher intervention or influence can capture a rich and complex account of the struggles, constraints and compromises within an agent’s life, their ethical and moral drives and their socio-political relations through stories and biographies (Bloom and Munro, 1998; Holloway and Jefferson, 2000; May, 2001; McCracken, 1988; Wengraf, 2001). This method is becoming more prevalent in business settings and has been used by Donaldson (2007) to show the polyphonic nature of the health care organisation, to reflect on the many voices and histories within an organisation and the range of truth claims that challenge the dominant norms.

The method is also extensively employed in post-structural feminist research to reveal system level constraints in everyday practices, to expose injustices, to raise consciousness and to give voice and empowerment to those who are perceived as marginalized in society (Bloom and Munro, 1998; Fletcher, 2001, Harding, 1997; Mckinnon, 1982; Oakley, 1981; Olesen, 2005; Roberts, 1990; Stanley and Wise, 1993). It is a process that enables a researcher to critically challenge their own preconception of a phenomena or context (May, 2001).

The interview itself is not a neutral method of data collection; it is a complex interactive process between historically and contextually situated agents and the researcher's conscious and unconscious motives, desires and biases (Fontana and Frey, 2005). It locates the researcher reflexively and emotionally within the context, at the interface of agents, stories and practice (Van Maanen, Manning and Miller, 1998). As discursive formation would premise, all discourse is historically constituted and participants in the interview process are not asocial or ahistorical beings, none can leave behind their past, their future hopes, their anxieties, prejudices and emotions and thus the superficial detail of response is highly complicated by a linguistic performance that intricately links with a particular discursive construct (Wengraf, 2001).

McCracken (1988) contends that the in-depth interview is a *self-as-instrument* (1988:19) technique and is optimised if the researcher seeks to match ideas and actions that reflect their own experiences, where the 'matching' process can help flesh out the meaning underlying a respondent's statements and narratives. McCracken (1988) further emphasises that this process facilitates the researcher's experience to apply a bundle of possibilities and pointers to the respondents' narratives. This approach appeals because of my profound knowledge of the context.

The framework on which I base my interview technique is adapted from *The Long Interview* devised by McCracken (1988) and Wengraf's (2001:Ch 6) *Biographical- Narrative Interview Method* as both propose an open-ended and lightly structured medium through which I can gather biographies, stories and narratives with minimal interaction, direction or inducement, but allows space



for me to probe their accounts, to elaborate their motives and contexts, using the respondents' language and phrasing (Denzin, 1989; Holloway and Jefferson, 2000; McCracken, 1988; Wengraf, 2001). For instance McCracken suggests it can probe what a manager would really mean by his term *quality* or *effectiveness*.

Although both McCracken and Wengraf propose a two-interview approach, one to gather stories and one to probe following an earlier analysis, I do not feel my context would allow the time for any lengthy intrusion and it may deter recruitment and I intend to compress both stages into one interview. What is useful is that their methods follow Czarniaswska's (1998) worthy advice of the need for flexibility, permitting me to adapt the technique in line with my own skills, intellect, experience and imagination where required (McCracken, 1988). A further ethical advantage to this open technique is that by allowing participants the space to speak the power differentials between the researcher and the researched can be eased (Minichiello *et al*, 1995; Oakley, 1990). However, I must emphasise that I am only using McCracken's (1988) and Wengraf's (2001) advice on method and continue with a Foucauldian approach to the analysis of the texts.

### **Devising the Questions – *Once Upon a Time in the West***

An agents' position shifts according to the nature of the question posed (Scheurich and McKenzie, 2005) and thus it is essential, in 'Foucauldian analysis', that my questions allow freedom and variability and do not lead the respondent towards any particular subject, but simply obtains stories and narratives about personal experiences of their professional life and allows them to relate this experience through their own language, analogies and metaphors.

Through my letter of approach (Appendix I) and information leaflet (Appendix II) the respondents are made aware of the subject of the research, as ethical governance requires, and also regarding my NHS background, which I state as clinician and manager, to gain credibility and to avoid any notion of 'taking sides'. McCracken (1988) cautions that I maintain a critical 'distance' and my need to stay silent or 'play dumb' is a useful hint as the familiarity with the

context may have allowed me to become too intrusive and thus endanger not only the content, but the researcher-researched relationship.

Wengraf (2001) proposes that a single question that requests their “*life story, all the events and experiences that were important for you*” (2001:119) is a suitable starting point to stimulate an unrestricted session where the interviewer relinquishes control. In some circumstances, this single prompt may be suitable, but I feel this may be expecting too much of the respondents and their powers of continuous talking in a business context. Taylor and Bogdan (1984) suggest I avoid a conversational approach and ask broad descriptive questions to evoke a storytelling response and then focus down with questions that compare and contrast. Skoldberg (1994) asserts that to elicit stories about past and present events and notions of the future enables the identification of relations of power and the drivers of organisational change and will emphasise the evolutionary nature of the organisation and provide clues to the historical constitution of their habitus. Consequently I divide the questions into three parts, initially asking the respondents to recount experiences of their past professional career, secondly their present role and finally to communicate their thoughts for the future, their selves, their roles, the organisation and the NHS.

Active listening is a crucial part of the interview (Taylor and Bogdan, 1984) to inform the second stage of the interview process and pursue some of the events that had been recounted in order to strategically gather more in-depth information about an event; it was essential for the analysis that an underlying narrative is revealed to substantiate the reason for telling an event.

What I found particularly useful in Wengraf’s (2001) approach is how it concludes with self-debriefing, which Wengraf (2001) considers is essential to improve one’s competency in the interview process. Therefore as soon as possible after the interview I free-associate about the interview, the transcripts of which are found in Appendix IV. Wengraf (2001) asserts that much can be forgotten as you leave the building, drive home or start talking to others. I found this free-flow writing a valuable way of relaxing after the interview and to reflect on my thoughts, what had worked and perhaps what did not. It also allowed me to note whether their experiences had matched mine in some way, a

dimension that McCracken (1988) contends is crucial in reflexive methodologies.

### **Casting the Actors – *A Few Good Men***

The rich data that can be obtained from in-depth interviews accepts that a small sample of respondents is sufficient and I planned to recruit between 6-8 respondents. In an organisation such as the NHS with its rich diversity of staff it would have been impossible to invite all staff groups to participate. Therefore I decided to focus on managers, in clinical and non-clinical departments, and senior clinicians (ward managers, ward sisters, charge nurses and consultant physicians) as I considered the habitus of these groups are more likely to have encountered the power/knowledge of managerialism and clinical governance in their day to day activities. I ensured before the recruitment that my study conforms to the Research Governance Framework for Health and Social Care (2005), the Data Protection Act (1998) and the requirements of the participating Trust. The South East Wales Local Ethics Committee waived the need for their approval as they were no deontological concerns and made the suggestion that the Human Resources (HR) department at the Trust might help with the randomisation. I appreciated their advice and the HR department obliged providing with a list of thirty names of senior managers, senior nurses and consultant staff. Clinical staff recruitment is restricted to the acute medical division as this was my particular area of interest and where the need for flexible, responsive and innovative working practices is paramount. I contacted all candidates in three stages over a six-month period by sending a letter of approach (Appendix I) together with an information sheet (Appendix II), ten to senior managers, ten to ward sisters and ten to consultants.

As I did not wish to coerce, the potential interviewees are not contacted other than by the initial letter of approach and I request that they contact me if they wish to participate. Where possible, on booking the appointment the nature of the questions and the open nature of the interview is highlighted and I explain that I was not particularly looking for anyone with any particular understanding of 'management practice'. Eight people replied, all of whom I interview, all in their place of work. Participants are also required to complete a consent form before the interview commenced (Appendix III).

The interviews are audiotaped using a digital recorder and downloaded directly onto my computer files. All the tapes were transcribed verbatim (see Appendix V) and the only modification is the removal of identifying data that could compromise the identity of my participants or their employing body. As transcripts cannot express paralinguistic activity, I have where possible denoted certain facial expressions, gaps, hesitations and body language where possible in the text.

Whilst I do not wish to destroy the multiplicity of diverse voices that emerge from my contextual exploration, part of my analysis clusters stories thematically in a way that corresponds to the discursive constitutions of my context as expressed in the earlier chapters. This section of the analysis process is aided by computer-assisted software, QSR Nvivo.2 (Sage Publications). I am conscious that the software unfortunately fragments text into certain categories and thus detracts from representing the uniqueness of each agent, but it is a simple and quick retrieval tool with which to identify fractal discursive patterning within my context as a CES and as such I consider its limitations acceptable.

### **Writing and the Impossibility of Representation – *Dumb and Dumber***

My earlier deliberations, with regard to re-interpreting the notion of validity focused on my inability to stand in a position of objectivity and to accurately represent the voices of my participants. However, reflexive representation goes much deeper than this and my authorship has an added responsibility to clarify my style of writing as I elucidate and explore my findings in the next chapter.

As a personal journey I write in the first person throughout this thesis and my remarks and cynicisms, whilst not ‘politically correct’ are genuine and spontaneous reflections of a situation; clues to the constitution of my self and as such I do not attempt to alter them. Guba and Lincoln (2003) support me, explaining that writing scientifically leads us to think the world is simpler than it is; “*Writing is not merely the transcribing of some reality...but a process of discovery: discovery of the subject ...and discovery of the self*” (2003:284).

For the purpose of clarity to the reader, the findings in part do follow a somewhat systematic and linear, but not chronological, structure that reflects the discursive constitution of health care as portrayed in Chapter Two but as a reader you will conclude that the texts that are messy (Marcus and Fischer, 1986) and do not neatly fit within one discursive strand. Messy texts are an excellent way of teasing out a range of interpretations for scholarly debate, perhaps questioning the legitimised way in which health care is currently presented by inviting my multiple voices to speak and to reveal their competing ‘*will(s) to truth*’ (Neitzsche, 1910).

Multiple voicing and the wide-ranging perspectives that this yields add to the validity of the findings rather than remove it (Hertz, 1997). Barthes (1989) conceptualises the author as creating merely a “*fabric of quotation, resulting from a thousand sources*” (1989:53) and the reader as “*the site where this multiplicity is collected*” (1989:54). Barthes (1989) however stresses the death of the author in terms of establishing a meaning of a text and like Derrida (1976) argues for a multiplicity of meanings. As author I am, as auteur, infusing my ‘presence’ throughout by interpreting the findings with my own experiences.

Thus I attempt to write within a post-structural framework that incorporates both the academic and the practitioner aspects of my self and attempts to breach the binary opposition of science and fiction by incorporating the rational, the emotional, the personal (Denzin, 1989) and the speculative. I write as if a narrator, in the first person; my interpretations are stories in themselves (Lyotard, 1984) and I apologise if I impose ‘academic’ jargon on my readers, as Grey and Sinclair (2006) suggests this engenders alternative relations of power that critical inquiry seeks to nullify.

Foucault (1984b) contends that *writing unfolds like a game* (1984b: 112) transgressing its own limits and breaking its own rules. I think what Foucault is alluding to is the position of power I hold as author, that my text will privilege a particular discourse and become a strategic act rather than a passive event. My inclusion or omission of certain events is inevitable, even if an unconscious act

and hence I must to ask you as reader to acknowledge this and understand that the findings only represent partial knowledge.

### Conclusion to the Chapter

This chapter has formulated a methodological approach appropriate for the critical disposition of this research and with which to inform its ensuing data collection phase. The chapter critiques the dominant relationship between rational and scientific knowledge and managerialist discourse and (re)positions this thesis towards the generation of phronetic knowledge that can emancipate the multiplicity of voices in my polyphonic context and reveal the relations of power that are mandated within the dominant managerialist philosophical approach. It is almost ironic that I attempt to stand objectively apart and judge the modernist values of scientific knowledge, as it is not my intention, as either a management scholar or NHS practitioner, to substitute it, but to promote integration through a multi-lens approach to knowledge, where the validity of ‘scientific’ knowledge may be enhanced by allowing the heterogeneity of savoir to continually evolve their field of secondary care practice.

In denying the realism that informs traditional positivist science, the methodological approach for this context has been shaped around the three principal post-structural dimensions, its dynamic, open and co-evolutionary ontology, its inter-subjective, historic and discursive epistemology and the non-unitary and subjective nature of its agents and those who interact within the micro-level, such as myself as author. Thus the chapter emphasises the fragmented and tenuous existence of reality where knowledge is neither a universal or fixed phenomenon, but is continually co-evolving through subjective interpretation and the consequent impact of agency.

The post-structural methodology is also informed by the problematic of language, that language is not a unambiguous or transparent medium of communication, but a strategic and political vehicle for the dissemination of knowledge and I therefore explicate the need to look ‘beneath’ language to the discursive constructs that inform agent practice. My selection of Foucauldian discourse analysis, as a frame of reference, is disclosed as one that can oppose

the phenomenological assumptions that adhere to the ‘metaphysics of presence’ that Derridean (1976) thinking dismantles. My linguistic ruminations also implicate my ability, as author, to represent the voices of my context with any accuracy and this chapter elaborates on the necessity of incorporating my reflexive and reflective self into the findings and analysis and concurs with my earlier comments that this acknowledgement can only heighten validity and not renounce it.

The final part of this chapter is the fashioning of a minimally structured interview method that is consummate with my methodological position and which can provide the space for my respondents to raise their unique perspectives and experiences of secondary care existence. The ‘biographical-narrative’ approach generated appears an eminently suitable process by which to gather substrate data, as biographical stories, suitable for Foucauldian discourse analysis techniques where I as researcher, listener and advocate can accompany them on a journey through their secondary care world.

**Chapter Six:**  
**(Re)presenting and Exploring the Findings**  
*-Snow White and the Seven Dwarfs*



## Introducing the Chapter

“*My Moma said that life is like a box of chocolates; you never know what your gonna get*” (Forrest Gump, 1994).

The purpose of this chapter is, as Foucault (1972) suggests, voyaging downstream to look at how discursive practice emerges as a consequence of the power/knowledge relationships between the discursive formations. Thus, I present the multiple voices that shape and influence the object of health care, seeking the relationships that exist between the *savoir* of agents and the *connaissance* of discursive constructs.

My exploration in this chapter reflects the main themes of the research and seeks the existence of discursive dominance or closure wrought through statements, or *connaissance*, that refer to a particular definition of reality, excluding or dissuading alternative bodies of knowledge and whether and how this influences the discursive practice of agents. In reality, I cannot differentiate between the *savoir* and the *connaissance* as I examine the micro-stories of agents, the heterogeneous, emotional, instinctive and even contradictory statements that constitute their unique, local perspective, simultaneously accepting, obeying and challenging unified claims to truth; does *savoir* turn to *connaissance*, as their truth claims are objectified through kaleidoscopic patterns of practice or does it dissipate through marginalisation, denied a place in the NHS world.

The journey I take with each participant is both a fascinating and enlightening experience as each voice represents a microscopic voice of history that (re)constructs the world of health care through diverse and subjective lenses. Their claims to truth connect with the practicalities of every day living (Miller, 2006) and you may think each voice stands in isolation, but voices are never singular, texts are never alone, but remain under the imposition of a dominating discourse (Fletcher, 1999). Each story and narrative expressed communicates legitimised and non-legitimised knowledge in an attempt to preserve their personal and unique representation of the field of health care, a formulating process replete with political intention and privilege that attempts to exert discursive closure.

My eclectic mix of respondents provides a series of separate mini-case studies; respondents are auteurs, each synthesising their uniqueness of self into the object; the concept of secondary care. Each statement and event, as discursive practice, reconstructs the object, even if only imperceptibly, as each respondent's statements and described actions appeal to or rebuff particular unities of discourses, (re)establishing *différance* (Derrida, 1976) in an attempt to dissipate the perturbation of co-evolutionary systems.

The chapter is constructed in three parts. I begin by exploring the 'profiles' of each respondent, in an attempt to elaborate on the constitution of their habitus (Bourdieu, 1977; 1991) and to represent them as unique agents. My descriptions aim to preserve the wholeness that thematic analysis destroys and seeks to explore their self, the discursive unities they legitimise and the statements and definitions they confront. The second phase of the findings delves into statements of the Trust Board, as portrayed by the monthly minutes, to assess their coherence with any particular discursive constructions and to recognise the anxieties and imperatives of corporate level experience. The last section is a thematic analysis that probes the discursive reality of secondary care, identifying inter-discursivity in the statements and practice of agents and the strategies being used to influence or dominate a particular perspective of reality. My major interest reflects the key themes of this research,

- i. Do mechanisms of power exercised through the managerialism attempt to maintain discursive closure in favour of a particular reality of secondary care.
- ii. In what way does the reality presented by the discourse of managerialism impact on the inter-discursive constitution of an agent's self.
- iii. Does the context reveal the existence of competing, dominant and marginalized discourses at the micro-level; in what ways are these legitimised, tolerated or resisted by agents and to what extent does this impact on their practice.

I complete the chapter by discussing how the discursive picture revealed is affecting the dynamics of the context, as a CES, and the way in which this affects self-organisation and co-evolution.

### Meeting the Cast- *The Canterbury Tales*

As in the *Canterbury Tales* (Chaucer, 1951; orig 1387) my collection of participants is diverse in terms of its tellers, but unified in having a common contextual orientation. Coghill (1951) said of the ‘*Tales*’ that it was Chaucer’s “*simple device for securing natural probability, psychological variety and a range of narrative interest...sharply individual [but] together they form a party*” (1951: 17) and I thought this a distinctly suitable analogy for this thesis.

By constructing a reflexive profile for each participant I attempt to promote his or her unique character in a seamless way that thematic analysis easily destroys. By teasing out clues from their underlying narratives I hope to understand the habitus in which my respondents locate their selves and the institutionalised dispositions to which they remain true. Do their selves align with the discursive unities described in chapter two and what cements this difference in place?

### **The Ward Manager’s Tale - *The Green Mile***

My first respondent, Liz, is a ward manager on the medical unit. I am a little nervous, it is some time since I entered a hospital ward and it stirs emotions from my past, but I am pleasantly surprised as I am expected although, in my ‘civvies’, I feel out of place. My arrival coincides with an unscheduled Community Health Council (CHC) visit, but Liz is seemingly unperturbed, explaining that “*They [the CHC] can pop in anytime unannounced*” (1, par 32) and I am amazed at her calm attitude to what I would consider disruption, but she infers that it is all in a day’s work. The interview takes place in a rather dingy and cluttered office, not particularly comfortable, but away from the bustle of the ward.

I am perplexed by the nature of the ‘ward manager’ role, a title that seems synonymous and interchangeable with ‘senior sister.’ This designation emerged with the inauguration of NPM, perhaps symbolically reordering the perspective of the role, superficially silencing any gender orientation, reflecting the politically correct aspirations of contemporary society and simultaneously acknowledging its management status. The latter point is of interest as although

Liz suggests that although the ward manager is responsible for a higher degree of delegated accountability, in the areas of human resource activity and budgetary responsibility, its autonomy appears hollow and a degree of powerlessness is reflected in her statement; “... *we were told [a unit] was closing ...and that in a week’s time we were going to have [extra] beds, no discussion, no negotiation with us, it was a done deal, “You’re having them”* (1, par 128). Liz’s frustration at the lack of consultation removes any notion of ‘empowerment’ and in contrast, presents a picture of hierarchical control and marginalisation that does not meet with Liz’s expectations.

The mood of the interview seems tense and I assume that the tape recorder is unnerving Liz; she suggests not, but regardless throughout the interview I become more aware of my respondent’s demeanour. On arranging the interview Liz seemed bubbly and outspoken, but the interview generates a climate of despondency, it talks of failure; stories I am aware do not usually have a positive intent and are expected to articulate breaches of expectation (Bruner, 1990; Denzin, 1989; Reissmann, 1993), but they seem to voice more than mere perturbation. In addition, Liz’s body language whilst starting fairly relaxed becomes more introspective and resentful as the exchange continues, reconstituting a negative dimension in her self; maybe the feeling of failing in her role and Liz, at times, turns away and hugs the back of the chair as if a comfort blanket. I possibly use the metaphor ‘resentful’ with hindsight, as it was only towards the end of the exchange that she expresses that she is feeling; “*a little bit sour, more sour than I usually am.*” (1, par 400)

The exchange is stilted and at one point Liz is almost silent and this perhaps prompts me to interact perhaps more than I wished or expected, in a bid to keep the atmosphere upbeat, creating a safe and trusting environment to speak openly. Whether this tactic worked is not clear, but what is revealed at the end is the reason for her low spirits and withdrawn posture, the response by a manager to a medication error that Liz had made a couple of weeks earlier. As a pharmacist, a background that Liz was aware of, my professional and personal experience ‘kicked in’ and I presented a position of empathy and reassurance as if a colleague; Liz may have thought it bit bizarre if I had dealt with it any other

way. In some ways I think that by this point, the ‘interview’ had completed and Liz had turned attention to relieving her ‘tortured soul’.

At first I consider the story about an error bares no relevance to power and managerialism, but my natural response to use the word *soul* in the previous sentence speaks volumes in terms of understanding Foucault’s (1971; 1977; 1979; 1980a) fascination with the oblique exercise of power. As Liz tells her story, as if to cleanse her ‘soul’ from shame and humiliation she is, in effect, reassuring her self of the truth. I reflect on how well this story represents Foucault’s (1979) apparatus of power, the confessional, in its effectual use of normalising the docile body. Errors are not deliberate or conscious acts, there is no need for atonement to eradicate them from the self through the confession, as if you were a willing victim, so for Liz its telling is not only a way of sharing anxiety and devastation, but the means to raise her voice in resistance to the response that her open confession generates. As a clinician, I was troubled at her line manager’s reaction; “...my senior nurse came to see me and said that they may have to take me down the disciplinary route over it...I was devastated for the patient, myself, and the whole ward. I felt I’d let them all down and so yeah, I am – I feel quite bitter, even though it hasn’t gone down the disciplinary route, I thought it perhaps could have been handled differently” (1, par 408)

Liz seems numb and her laugh emphasises bewilderment at the scene she relates rather than signifying any triumphant relief of evading punishment. My initial concern, that this ‘knee-jerk’ response flouts clinical governance policy may be forgiven, but what compounds this event it that when her nurse manager realises that they have over-reacted they still tell Liz to expect a “*telling off*” (1: par 412). At first, I consider this the rational unemotional attitude of management, denying that managers can be wrong, a kind of impression management, a statement of *différance*, and of impositional power and supports the thought that nurse management endorses the dominant rational paradigm of management where emotionality is removed (Bolton, 2002; Bone, 2002; Brown and Brooks, 2005; davies, 1995; Maddock and Morgan, 1998; Mark, 2005; Marquis and Huston, 2006; Roussel, Swansburg and Swansburg, 2008). It also displays a clear example of the military disciplining that Foucault (1977) describes as the

first stage in the creation of a docile body and the ‘infra-penalty’ of disciplinary power.

At the earliest stage of my data collection, our exchange on this matter reinforces not only how researcher objectivity is futile, but also the fluid ontology of self and how past experiences easily deflects discursive practice away from institutionalised commitment and towards disappointment and distrust. The reaction to the error appears as a struggle for enunciative power, to normalise the ‘nurse managers’ position as an authority of delimitation for nursing, but the discourse revealed is historically and institutionally formed (Salvage, 1990) and does not necessarily emanate from managerialism, but from the profession itself.

So my first interview has not proceeded as predicted and as Czarniawska (1998) suggests, I needed to adapt the process accordingly, but it teaches me that getting people to talk enthusiastically, willingly and endlessly without interaction is not simple. Nevertheless, the interview does generate the required storytelling and narrative mode of expression that I had hoped for and in retrospect, my comments are not coercive, but reiterative.

Mirroring the discursive unity explored in chapter two, Liz reflects that “*the patient*” is the reason she went into nursing and throughout the interview Liz’s stories, although integrating multifarious issues, such as medical outliers and patients waiting on trolleys, her underlying narrative continually refers to a concern for the patient (1, par 152; 156; 168; 184; 314; 325; 344). It is as if through its telling Liz is able to assess each situation unconsciously considering their effect on patient well-being. Every storyline is constituted inter-discursively, entwining a performativity discourse, in particular, patient throughput, with the derogatory effect on patient care, re-legitimising the importance of this aspect of a nurses’ work and cementing an institutionalised image of relational and participative care and any use of managerialist vocabulary is noticeably absent.

Liz calls herself a *control freak* (1, par 56) and a “*Jack of all Trades*” (1, par 349) and suggests she doesn’t delegate enough and I assume that as a ‘manager’ she absorbs the dominant managerial discourse, that clinical work should be delegated, but Liz in contrast argues that the need to play a participative part in the ward is essential; *you can’t monitor performance, you can’t judge the mood of the ward unless you are out there* (1, par 56) mirroring the opinion that a relational style of management is essential (Currie, 1996; Westmoreland, 1993) and that nurses aim to harmonise the expectations of the service and the traditional moral standards of the clinical ‘work ethic’ (Cooper et al, 2002; White 1986). Of interest is that her unconscious use of the phrase *monitor performance* highlights the incursion of managerialism and possibly a loss of trust in her everyday experiences and yet the underlying narrative always defines performance in terms of a patient’s dignity and care.

### **The Sister’s Tale - *Mary Poppins***

Mary is a nursing sister with clinical teaching responsibilities, based at ward level, and seems accustomed to interacting with others in what comes across as a semi-formal manner, pleasant but factual, painfully factual on occasions. Similarly, the interview takes place in a rather dismal but comfortable room, just off the ward.

From the outset the way Mary copes, tolerates and negotiates the impact of diverse systemic discourses and their ‘strange attractors’ is admirable and commendable, although her anxiety and frustration is clearly voiced, both linguistically and para-linguistically throughout our exchange. Emotions range from almost tearful when relating her struggle to maintain *her* standards of care (2, par 113, 127-132, 255 -260) to complete cynicism when describing the need to involve the Chief Executive in the discharge process, using laughter and parody to drown out the absurdity of events in which she finds herself (2, par 57, 400, 546).

Mary has experienced the acute health care sector for over 30 years, but I sensed that she felt that things were as regretful as they are at the present time. Echoing the comments on low morale in the NHS (Hehir *et al*, 2006 Salvage, 2006; Smy,

2005) Mary speaks as if an authority of delimitation for the nursing role, stating; “*we’ve pushed people to the limit of their generosity... at the moment morale is very, very low... we’re proud to be who we are, proud of our job, proud of what we do, all nurses are proud of what they do, we’re just a little bit down hearted at the moment, a bit brow beaten by it all because they haven’t got time to care for patients, they haven’t got time to do nursing, they’re too busy doing everything else that everyone else wants them to do*” (2, par 94).

Mary seems to reflect on the Chief Executive as the villain of the organisation and appears isolated, not belonging to the Trust, which she describes as if a remote governing, if not interfering, body, quite separate from the ward on which she works. Mary’s stories emphasise resistance by a continual reference to being distracted from giving patient care and I sense that Mary wishes to build boundaries to protect her environment from the external noise. Mary seems very open and trusting and I truly felt that by relating her stories Mary, like Liz, resurfaces the normative discourse of nursing legitimised in her self, liberating an archival perspective of caring that reinforces the discourse explored in chapter two of the caring, self-sacrificing angel (Salvage, 2001) even telling me that patients consider them *angels* (2:par 233).

The way Mary describes events and processes are painfully detailed and I almost wince at the way she describes how to wash a patient (2, par 459), but this detail performs a very important purpose; the literature (Kalisch and Kalisch, 1987; Royal College of Nursing, 2005; Savage, 2006; Smy, 2005; Strasen, 1992; Wood, 2000) suggests that the process of washing and caring for patients is subjugated and devalued, but it is part of the caring discourse that the nursing profession is struggling to retain in the face of modernist de-professionalisation. Mary’s emphasis on the intricacy of the process is re-elevating washing as a highly important skill.

The light structure allows Mary to lead the interview and on each occasion these are completely focused on her role, rarely, if ever mentioning other aspects of her life. Maybe as in Ishiguro’s (2005) novel, to diverge into non-organisational matters would be deemed unprofessional in the hospital office. The inter-



discursive constitution of Mary's stories reflects those of Liz and common themes are already evident as events revolve around current hospital initiatives and reinforce the subjects raised in the corporate minutes. In similarity to Liz, Mary frequently expresses the relational side to caring, saying that this attracted her to nursing and is where her future belongs; *"I don't want to a ward manager's post that would take me further away from patients. I feel I still need to work with patients"* (2: par 217).

The underlying narratives re-establish a discourse of care that pays high regard to the relational and patient-centric nature of care, providing a clue to Mary's prevailing dispositional constitution; *"Being a nurse is what is inside you, its how you come across to people and what you want out of the job and what you give back to people... it's not what you can do academically its what you can actually do as a person, as a nurse"* (2: par 23); a comment that reinforces difference between the academic and practising fields of nursing.

Bourdieu (1991) believes that agents choose to interact with fields that align with their dominant dispositions and Mary's anxiety and critique, expressed on several occasions, implies a hexis in conflict with the increasingly modernist and scientific discourse. I feel I understand what Mary means, I sense that like me, Mary remembers a past world that reinforces the compassionate side of nursing (Wright, 2004) and by raising this Mary attempts to relocate these values in her future world. Mary's stories continually call attention to the preserving nature of her actions (Fletcher, 1999) reducing power differentials to complete the task, even if this requires the manipulation of consultant colleagues (2, par 297), although a disruption is noted as, although as Mary attempts to portray the ideological 'sacrificing angel', she comments that nurses are not necessarily endowed with righteousness or virtue, evoking thoughts of Goffman's (1959) notion of dramaturgy and Hirsch's (1985) concept of emotion work.

Mary is very proud of her profession and her attainment to the role of sister, which, for her, signifies the pinnacle of nursing. She confided after the interview, as she walked me to the door that it was the proudest day of her life,

“*putting on the navy uniform*” and throughout the interview she frequently impresses upon me her position as a ‘*sister*’ but suggests the autonomy of the role is now less potent (2, par 321, 591). For Mary, the uniform and the term *sister* retain a high degree of symbolic power (2, par 229), a way to re-establish the status, experience and *savoir* of ‘*sister*’ as an authority of delimitation in an increasingly modernist environment, a voice that speaks for the profession, the patients, the public and her colleagues; a voice that resonates with Mary’s past.

Mary also discloses in the interview what she describes as a *reflection*, (2, par 272- 280) composed six months earlier at the request of a senior manager, who had found her distressed one day and in whom she seemed to trust and respect totally. The reflection (2a) candidly reveals the frustrations, stresses and dilemmas of everyday nursing practice. On my first reading I was surprised at how beautifully written this essay is, not a diatribe, but an even-tempered and clear description of the contemporary field of nursing, that fully supports and embellishes Mary’s narratives and story’s. Its existence demonstrates that however docile the body might look superficially, resistance through action exists. It may also have been a somewhat cathartic experience initially, but the interview suggests that this turned into one of frustration and angst (2, par 280) when the lack of response to this open confession appeared to have been disregarded. If the Trust Board had discussed Mary’s case, it had been silenced in the minutes.

The reflection voices aspects of everyday practice that, as Foucault (1986) suggests, reveals *schemas of valuation that are generally accepted* (Dreyfus and Rabinow, 1986:3), values and attitudes that Mary legitimises together with the emergence of new standards of practice. Mary explains that the title, “*Give Me a Minute and I Will Be With You*” is a phrase she uses continually throughout the day;

*“How many times a day do I say that, in fact how many times an hour do I say those words. I feel as if I say them constantly, if not to patients, then I say them to my colleagues, relatives, other members of the multidisciplinary team, on the telephone, face-to-face and even under my breath! Quite which minute I am*

*referring to, I am not sure. I am not even sure of when or where I am going to find that minute to go back. I never seem to achieve one thing without getting involved in another.” (2a; par 6)*

This essay that supports Hardeveldt (2006) by emphasising how a discourse of surveillance and the need for documentary evidence is proliferating, but Mary re-defines the object of caring as relational and intuitive, but intangible; “*We talk about Nursing CARE, Standards of CARE, the Essence of CARE, Fundamentals of CARE, CARE Plans etc, yet we seem to forget that nurses as teams and individuals CARE in a way which can not be written down*” (2a, par 33)

### **The Directorate Managers Tale - *Rebel without a Cause***

My previous interview (re)instills confidence in my approach, but as you think your skills are improving the unexpected occurs. I am a little anxious about meeting the directorate manager and I am immediately impressed that he has his own office, even though its décor is a little meagre. I note the dead plant on the windowsill.

James has a nursing background, but clarifies that his role is now non-clinical and primarily focuses on performance management. James practiced as a nurse for several years and I thought that James’ self might have been trapped between two discursive domains; nursing and management, but this was not evident in my interpretation. James began his career as a manager in the private service sector and admits that his nurse training provided an advantageous position to enter healthcare management (3, par 15) at a time when NPM had hit the NHS with full force.

I can barely call our exchange an ‘interview’, as my intervention is minimal, almost absent, and any control on my part is severely limited. At the time I consider this lack of direction in a negative light, well, panic, but with hindsight the passionate, free-flowing style unleashed almost simply by my presence in the room is hugely rewarding in terms of understanding his worldview and the discursive constructs that interfere with his achieving his objectives; something

genuinely emergent and unpredictable. James speaks candidly, although is a little hyperactive, and as the interview progresses James irritation at the current health and social care system intensifies, his body language relaxes and he reinforces his frame of mind with grotesque facial expressions and by picking up documents and shaking them at me.

James' describes himself as *hyper-political* (3, par 59) and frequently offers opinions on world events ranging from the Iraq war (3, par 226) to EU directives (3, par 718) and from climate change (3, par 597) to cigarette marketing in Pakistan (3, par 474-483). James recounts his father's illness and his experience of the health care system in Pakistan, where money and personal connections are key factors in the timely access to treatment. I sensed his father's influence throughout (3, par 1094, 1117) and felt this experience had impacted on his inner self, engendering his frustrations, but creating a semantic desire to make the Welsh NHS system both appreciated and successful, and I don't think 'success' for James was truly achieved by merely meeting performance targets.

Throughout the three and a half hour interview the resounding theme of James' stories orient around the political interference in health care, the way performance targets drive Trust priorities and his role, the monitoring and policing of any situation that threatens performance, his performance. He comments despondently that health care has; "*eventually come down to how many people will be treated*" (3: par 53) and that "*we fail because of the sheer politics involved*" (3, par 738). This perspective contrasts my earlier opinion, as it did imply that James thought health care was not simply about numbers and in doing so James emphasises how a political surface of emergence is creating the quantitative conditions around which health care is considered, politically, as successful.

Regardless, James' stories legitimise performativity in the discursive object of health care, through statements that recount the dilemmas of *trolley wait targets* (3: par 26; 991), *inappropriate referrals* (3:119; 522; 538; 546), *referral to treatment times* (3:194; 265; 554), *total waiting times* (3; par 202; 265; 554) and

*admission avoidance* (3: par115; 138; 652; 706; 1050). James does not criticise these norms, considering that performance targets remain essential, suggesting a paradigmatic acceptance of their evaluative logic as universalised in mainstream management theory (Adcroft and Willis, 2005; Bridges, Dor and Grossman, 2005; Cutler and Waine, 2000), but James had not worked in an industry where the rationality of targets had not been used, they had become an expected norm, inscribed ideologically on his self.

James' way of speaking, although inexhaustible, resonates with a managerial discourse, almost academic at times, using many acronyms and jargon and applying private sector analogies (3, par 30) to explain his thoughts and dissatisfaction. James' 'objectivity' focuses beyond the hospital walls, merging a wealth of diverse discourses from the whole of health and social care, although his use of *we* clearly identifies him as belonging to the Trust and James' comments, whilst fractious, frequently appear as enunciative acts from one serving as an authority of delimitation for the Trust. Whether this was by virtue of his status as manager or a characteristic of his personality is not clear, but James genuinely accepts this enunciative function as part of his current role. Bourdieu (1991) would assert that James' dispositional status would have attracted him to a role that was commensurate with his hexis and maybe his cultural background expected of him the high degree of status, responsibility and authority that a position in management afforded.

With hindsight I am not surprised that his narratives and stories recount abject dismay at social care and primary care medicine as these appear as the two key discursive unities that impinge predominantly on his expected performance. There is a noticeable absence in the narratives of the topics of quality, safety or clinical effectiveness from a Trust perspective and his statements; "*Doctors are working their socks off*" (3, par 715) and "*if you look at quality, the Trust is performing now*" (3: par 538), suggests that from his perspective quality and performance already exists, stimulating my thoughts of the *managerial meta-myth* (Adams and Ingersoll, 1990), the political meta-narrative of waste and inefficiency. What is reassuring is that not once does James subjugate or criticise his clinical colleagues and whilst one story resoundingly implicates

clinical incompetence (3, par 1030), James' irritation relates to the needless admission.

Although I suggest that James legitimises a managerialist discourse, a clear challenge to scientific management emerges when James (3, par 30) is unexpectedly cynical about how linear processes from manufacturing has been foisted upon the system in an effort to enhance performance through a mechanistic and modernist perspective of the patient journey. I revisit this story later in the chapter as interestingly, Mary told me the same story; I get the feeling of *déjà vu*.

### **The Senior Manager's Tale - *Star Trek: The Next Generation***

Patrick is a senior manager overseeing both clinical and non-clinical services, a position that seems to have emerged to conjoin fractured relationships between professional and non-professional fields, a disjuncture that possibly intensified as a consequence of the NPM philosophy of the mid 1980s and the 'contracting out' or 'privatising' of non-clinical services. Patrick is a fellow pharmacist with whom I had brief working relationship during my training, a long time ago. He was quiet and reflective individual then and I thought that his experiences of management might have changed him, but he remained the chirpy, but unperturbed character that I remembered. The interview took place in Patrick's office in the management block, a distance away from the hustle and bustle of the wards.

Quite soon into the interview and I recognise that Patrick is as much a listener as a talker; memories of James resurface, but the way the room is organised means that I am directly in his line of sight, engendering a greater engagement with the respondent than I would have liked. I remember the need to stay flexible and I am beginning to accept that to expect free-flow talking and boundless stories in my context may have been ambitious. Patrick is not a natural storyteller and at times, the conversation seems superficial and guarded, as if not wanting to disclose anything in a critical manner; if Patrick has a style, blame is not it.

In many ways this interview, for me, is comforting, following three interviews that left me feeling dismayed, frustrated and angry at the system. My reason for this is that I aspire to a philosophy of management that calls for collaboration and even though Patrick does not use the term, *per se*, the underlying narrative of all the events he describes argues for a greater co-evolution between the multifarious services that support the clinical areas (4, par 80, 112). Patrick emanates a perspective of management or some may prefer the expression 'leadership', in the true spirit of complexity, what Mitleton-Kelly (2003a) would call an enabler; managing by not managing. Patrick's self is clearly influenced by a discourse that privileges performativity, but mollifies any potential clinical versus performative conflict not by dictating or controlling but by engaging the wisdom of front-line staff.

Patrick appears to oppose the meta-discursive norms of managerialism (4, par 80, 164) and I recognise my self in this scenario. This 'anti-managerial' inconsistency is reinforced by Patrick's boss; "*My boss at the time felt this [the closure] should have a very clinical focus rather than a capital focus, closing buildings is one thing but actually integrating services into [the Trust] was a different issue and I think that was a very bold move because traditionally closures of hospitals was done on a process basis, you close this, you close that, where as he argues and I supported him that if you are moving [new services] into [the trust] then clinical practice would have to change*" (4: par 52). Patrick's boss is also an ex-clinician who acts as an authority of delimitation, in activating and legitimising a socio-centric and clinical discourse, emancipating the clinical and professional voice within that of performativity. The fact that Patrick describes this as a *bold move* suggests to me that this 'complexity' perspective may not be the norm.

Patrick's allegiance to the clinical focus is further revealed in the statement; "*[I] had to make sure the building work was synchronised with the clinical change*" (4; par 56). I note the way this sentence is ordered, as it reveals that, in Patrick's self, clinical services are of prior importance and that building work needs to synchronise with this priority, whether this had been a conscious decision to ordinate clinical work over the building work, I cannot tell, but it may well

influence order through marginalisation. Having had first hand experience of hospital refurbishments this is a refreshing feat and wondered if the closure worked this way in practice.

### **The Clinical Governance Manager's Tale - *Miss Marple Investigates***

Jane is responsible for clinical governance and her role orients around what she euphemistically calls *quality consumer relations* (5, par 33) and *patient experience* (5, par 44), what others may call 'complaints', and I feel she has evolved a 'sixth sense' for handling such sensitive issues. In an NHS that seems constantly under criticism, it may be understandable that management jargon attempts to silence the negative impact of the word *complaint*, strategically repressing its potency and substituting it with a language of beneficence, although Jane legitimises the metaphor *complaint* (5; par 99; 203; 207; 214; 222; 249) frequently during our exchange; complaints may be suppressed but complaints still exist.

Jane's frustration *at the system* (5; par 40) is evident from the start and I wonder if this was a key factor in her agreeing to take part, a statement in itself, the need to raise her voice against the confrontations in which her self is placed. However, I must be cautious as my self is sensitised, again seeking negative comments to support my own truth claims. Jane claims that the organisation is going through "*a radical shake up*" (5; par 482) and is *struggling* (5; par 508; 564) against continual change; "*we don't seem to be able to turn that corner and move on*" (5; par 564). In defence of her own critique however, Jane adds; *it's a lovely place to work but it's quite daunting because there are huge issues we are dealing with*" (5; par 588) and suggests "*I don't think the Trust has the answers*" although wryly adds; *I certainly don't think the Assembly have*" (5; par 588).

I feel I understand what Jane means and can understand why throughout our exchange, Jane's self vacillates between different discourses, like me, Jane is caught in the inter-discursive constitution of a modernist health care environment. Her stories become more frank as she reads aloud from documents to elaborate her irritation and what is apparent is a self oscillating on a



continuum between the patient and the Trust and her stories, extremely emotional at times (5, par 405-432), indicate a battle in this dual allegiance.

Jane accentuates the social value of her stories, portraying herself as a ‘lifeline’, a listener, (5, 405–432), but emphasises proudly that in doing so she represents the Trust and her statements inter-discursively accommodate the patient, the emotional nature of health care and the performance focus. Jane’s manner echoes Harding and Learmonth’s (2004a) findings that suggests that health care managers aspire to an image of rationality and organisation, but in reality that this is frequently compromised, indicating the fluidity of self in both seeking and refusing structure. Although not trained clinically, Jane’s role is akin to Friedson’s (1994) notion of the *professional worker*, performing tasks that afford greater social value, diverting commitment towards the socio-centric. It impresses upon me the shallowness of stereotypical constructs of management.

Jane attempts not to cast any blame on the Trust as she claims that; “*its all about consultation...it’s how we communicate and how people understand what we are trying to do*” (5: 107) but Jane is not passive and critiques the corporate approach; “*you need to tone down the language, forty slides is way over people’s heads, shut it down, make it more succinct and in plainer language*” (5: 493) and by doing Jane’s discursive practice re-orientates discourse socially. Jane’s freedom to criticise her peers is of paramount importance recognised by Foucault (1988) and in the theories of complexity as a stimulant of system transformation.

At first, I think critically about this story of a high powered management tactic, blinding the ‘public’ with jargon and perhaps rhetoric, but let me think laterally in this case, the need to use such tactics, the need to perhaps persuade, manipulate or silence. I am not sympathetic to their plight but I wonder if it’s not because managers want to act in this way, but need to. As Harding and Learmonth (2004) conclude, managers define a particular privileged perspective of health care and draw its linguistic boundaries because they need to defend their organisation, but Jane makes no comment on the validity of the truth

claims posited, perhaps practice as inaction, reinforcing and fixing the authority of the speaker and the reality that they portray.

However, an irruption occurs as Jane becomes very blunt in her revelations and exposé about the Trust managers, her voice drops markedly, conscious of the tape recorder and she almost mouths her words. She is keen to talk but I sense no evidence of self-interest, merely job and patient satisfaction. Bourdieu (1991) contends that conscious and rational action is often under the unconscious influence of morals and emotions and in some ways this may explain how Jane's self shifts between contradictory and contested discursive statements; compromised and perturbed this should generate the adaptive potential that can promote self-organisation and co-evolution, but do Jane's stories reveal this dimension? In contrast I interpret a patterning of a discursive reality that reveals Jane's legitimisation of a top down modernist approach to governance, demonstrated by stories that reveal increasingly detailed monitoring and surveillance techniques, the application of linear processes and copious documentary requirements.

Of further significance is that Jane's stories disclose the public voice, a surface of emergence that I neglect in my earlier chapters, demonstrating the intricate discursive constitution of my context. Two incidents reveal how Jane's empathy, maturity and experience are able to alleviate a patient's anguish by applying a highly relational and practical rather than an intimidatory style of behaviour. Fletcher (1999) contends that relational skills are able to *smooth potentially explosive situations* (1999:58) and Jane's stories again reflect Fletcher's (1999) concept of *preserving*, where her action is focused on protecting each incident, to prevent any intervention that is likely to exacerbate the situation, for Trust and patient (5, par 335, 440). As Jane takes on responsibility for this complainant the challenge for her is sorting out the problem, especially as she suggests that it places the Trust in a good light, but her reward is clearly voiced in an altruistic direction when she relates; "*I was the only one who ever helped him*" (5, par 436)

Jane reflects; “*if my manager was speaking she’d say I get too involved, but its very difficult not to because when someone is angry, their complaining, and I want to put it right...how can you not be ...that’s why I love my job, for every bad thing that happens there are some that are really good and you think, yes, there’s a positive outcome. So it’s a weird job*” (5, 399- 450).

What this reveals is a form of self-enunciative functionality as Jane speaks as an authority, mobilising a socially orientated domain of knowledge which Jane has legitimised, perhaps as a result of her historicity, a patterning of discursive practice that copes with the emotional context of this situation and accepts rather than denies its emotive effects. I wonder if Jane’s manager considers that *getting involved* is a flaw, an emotional ‘weak spot’ in the face of contemporary NHS management rationality, neglecting the understanding that relational practice can defuse a situation, moderating barriers to communication, dissipating relations of power and embracing relations of trust. Jane’s statements represent an authority of delimitation for a relational and emotional field of practice, which may reflect why she considers it a *weird job* in the midst of modernist expectations.

Fletcher (1999) asserts that relationships are important in the protection of a project and do require effort to sustain, emphasising that relational dispositions engender a sense of doing ‘whatever it takes’ and even personal sacrifice. One story does conclude with Jane nurturing reciprocity in spite of the continued wrath of her interdependent foil, and then ultimately offering the ‘personal sacrifice’ (Fletcher, 1999:49), but as Jane describes how they were both in tears on the phone (5, par 409) I feel that this invitation is not in any way manipulative, but a response to an emotional reality; for her its not about winning battles.

### **The Intermediate Care Manager’s Tale – *The Negotiator***

Jo’s office is secreted away in the entrails of the hospital building, but is comfortably furnished, but I sense Jo is apprehensive and her wry smile indicates that she is intrigued by the open and unstructured interview. Jo has a very matter-of-fact, almost cynical, but jocular personality; “*people know I’ll*

*say things the way I see them and I won't mess around with it...we all waste enough time without making mush out of everything that is really straight-forward"* (6, par 314). I had the impression she would not suffer fools gladly. I attempt not to act as one.

Jo is an intermediate care manager with a nursing background and is responsible for the smooth passage of patients between the hospital and the community; "*I manage the delays*" (6, par 166). The need for such a role appears to substantiate the existence of *delay*; a term I am beginning to note is entrenched in contemporary health care, politically reinforcing a discourse of inefficiency, just by its saying. The frustration of Jo's job is related throughout the interview as she weaves her way through the *maze* (6, par 338) of health and social care with the hope of negotiating a suitable outcome for her patients. As in previous interviews the fracture between two delineations of care is reinforced.

The necessity of such a role is a fairly recent development and Jo's stories suggest its performative underpinnings, the need to quicken patient throughput (6, par 116- 124, 150, 166, 190, 246). Jo explains that the *dependency*, *expectations* and *throughput* (6, par 50) of patients are all very different to her early experiences and I wonder why this role has been removed from nursing role at ward level, but narratives imply that the fragmentation of health and social care (6, par 290), fiscally and thus bodily, requires a higher degree of negotiation for community based support and thus supports the lack of co-evolution expressed relentlessly by James.

Jo instinctively understands the need for inter-relational working (6, par 50, 190) and her stories reflect Mary's as they frequently return to her training days (6, par 50, 62) and her past role on the ward (6, par 62, 73, 81, 101), where she describes her *leadership* role as participative and supportive (6, par 100) but almost mourns the loss of interdependent and relational practices; "*it was much better organised, people knew each other so helped each other out*" (6, par 50) and it is evident that she applies the same relational aptitude in her present job (6, par 148, 246). Jo states that she doesn't cling onto "*the good old days...there were some good things, but there were some very bad things as well*" (6, par 2)

but in contrast says that; “*when you are taught a set way, that’s what you expect to keep going.*” (6, par 50). Jo’s comment relates to institutionalised standards of care and again I recognise how this mirrors Liz and Mary’s concerns. I sense Jo is frustrated in her new ‘pseudo-managerial’ role and she seems sadly unfulfilled. I use the prefix *pseudo* as stories suggest the lack of autonomy, or perhaps the need for hierarchical approval, which maybe emanated from having an unexpected freedom to act after her previous role as a ward manager.

I feel my emotions rise as I reflect on my own experience as a departmental manager as I too miss my colleagues and the mutual sense of support they brought; there is no hint of positional power, only relations of trust. Jo asserts the need for transparency and openness; “*if a mistake happens, and they do happen, its about being open about it*” (6, par 101) and this reminds me of Liz’s tale; I feel there is a subjective connection between the three of us, by virtue of common experiences suggesting how ‘outsiders’ are unable to accommodate such human frailties without having felt the distress of such a situation. Jo concludes; “*there’s a lot of talk in the health service about being open about it, but I don’t actually see it happening*” (6, par 101).

There are several instances where Jo’s narratives reiterate those of the other nurses, her description of the evolving role of the nurse (6, par 148) is not dissimilar to Mary’s reflection and I wonder if their paths have crossed or whether this convergence depicts a ‘hot topic’ among nurses that challenges the contemporary modernist discourse of professional nursing. Of course, I should not be surprised to see patterns emerging especially within the same profession, but it appears that either their voice is not heard or as Bourdieu (1991) suggests, they are not afforded the social space in which to raise it. I am beginning to believe that the skills of the nursing profession remain *invisible* (Bilton *et al*, 2002); their work is *ordinary* work (Foucault, 1980a); trivialised and undervalued, as the academic literature suggests (Corby, 1997; Davies, 1995, Fletcher, 2006; Lane, 2000; Melia, 1987; Salvage, 2006)

### **The Consultant's Tale - *Ghandi***

Liam is a consultant physician working between two directorates, on different hospital sites, within the Trust. Liam has only been a consultant for a couple of years and suggests he is less exposed to the 'managerial' side of medicine (7, par 36), which may explain his gentle and relaxed temperament. I apologise for that judgmental opinion, it is cynical, but a genuine, retort, that provides a clue about the constitution of my self and its obstinate behaviour as I have met two managers who do not conform to the conventional management discourse. My self is coming under attack from a diverse image, but my experiences of managers are burnt into my soul, I am not sure if I can or want to forgive their insensitive actions.

At first I am disappointed not to have the stereotypical diatribal response expected of a consultant and I wonder if a new breed of consultants is emerging whose discursive practice normalises a relational discourse rather than the hierarchical and paternalist stereotype. The exchange is fairly positive and buoyant, although Liam is somewhat weary after a long day in the coroner's court, where although the outcome was 'natural causes' I sensed that the cross-examination had taken its toll on his conscience. Liam elaborates on the *catastrophic event*, later in the interview (7, par 279) and I felt that his aside; "*it's easier to accept that everything was done and you can see everything was done*" even though, he concludes that, "*...its difficult to accept*" (6, par 283) in some small way generates acceptance, as he unburdened a sense of relief that it was over. Possibly my being there provided him with a stranger to 'confide in' as he re-establishes his confidence and belief in the system in which he practises.

Liam is not a natural storyteller and throughout the interview amusingly jibes; "*Go on give me another prompt*" (7, par 86) and "*What else should I talk about?*" (7, par 40). I think he felt a little uncomfortable, as I felt others had with its minimal structure, but I tried not to lead the exchange into any new area that he had not raised himself and allowed the storylines to divert naturally into a discourse of his choice. I recognise, in Liam's stories, how agents do have a unique subjective perspective as he states; "*those changes have been difficult to*

*analyse because I'm moving through the system and seeing those changes evolve"* (7, par 36).

Liam recalls the long working hours that persuaded him to seek employment abroad but contends that; *"I was fortunate to have a number of, now, Professors...a great group of trainers"* (7, par 36) and I wonder if, as authorities for medicine, they inscribed the norms of a medical discourse that orientated around a patient ethic, into Liam's self, because regardless of where they start Liam's stories revert to a patient orientation. Even a discussion on medical training ultimately reflects on a patient focused narrative; *"I think that the junior doctors' home lives are considerably better, and I think the junior doctors, in the long term, will be less qualified and therefore the whole population is at risk"* (7, par 52).

Liam's stories also reinforce the prominence of the discourse of 'delay', arguing that; *"if you have the wrong people in hospital, you're doing no one any favours"*, (7, par 271), but Liam tells of a project where his ability to break down the boundaries between social care and health care by integrating these sectors at ward level has improved care for *"older patients, with complex care needs...using acute interdisciplinary [team] where we're actually able and have the time to communicate with each other, because having the time to communicate creates much more efficient working, to leave everything to a once-weekly [team meeting] allows things to be put off"* (7, par 120). Of interest, is that other respondents make reference to the exact same need for interdependent working and connectivity, but Liam implies that it is the authority mandated in the consultant voice that allows this project to progress (7, par 149, 185).

The recurring theme of patient throughput emerges repeatedly in the interview; an inter-discursivity immersed within the normative logic of the clinical field, but it is clear that Liam places himself as the patient advocate, an enunciative modality, legitimised by his consultant status and training in particular for *"... a group without a loud voice who at a greater risk of being squeezed."* (7, par 270). However, to contrast my perception of the power/knowledge of medical

discourse, Liam's interview also provide a contrasting account of the power relations that exist in the wider eco-system of health care, where medical knowledge is marginalised and surmises that; "*where there is a change, there are likely to be winners, but there are still likely to be some losers*" (7, par 40).

### **The Medical Director's Tale - *Top Gun***

This is my final interview and several weeks have passed and I feel I have lost momentum, as if I am starting afresh. However, it is worth the wait as David, reaffirms my epistemological perception of plurality and difference with another inter-discursive perspective of health care, where the 'medical discursive unity' is harmonised with that of performativity.

I use the term 'harmonise' as it seems that David's self is accepting of the struggle between these two opposing discourses (8, par 48- 56). David is very calm individual and, although uncomfortable at the open structure of my interview, he presents a balanced and diplomatic opinion, an able negotiator between clinicians, managers and commissioners. What is noticeably different is that I feel the need to establish my credibility, to demonstrate my understanding of NHS policy in Wales. I assume this action on my part is due to his status and eloquence of expression, but this indicates my legitimisation of his position in authority, a symptom of my self, I reinforce difference perhaps an outcome of my allegiance to institutionalised values.

The interview is shorter than the others and does not generate many stories, *per se*, but does offer a narrative description of his inter-discursive self as it attempts to balance medical and managerial priorities. The interview also generates a rich picture of the 'club culture' of the medical profession; "*it's very much a social thing, you get to know your colleagues, children go to the same school*" (8, par 17), the power relations between the clinicians and managers and the tussle for authority (8, par 48-64). David became the Medical Director after a few years as a consultant surgeon when he became "*interested in management and processes, how to improve patient flows, basically and outcomes*" (8, par 10). The task-based priority of performativity is clearly ordained in his statement.



David states his clinical activity is infrequent, although enough to stay a competent practitioner (8, par 25) and argues that it is confidence that dwindles rather than competency. David talks of his profession frequently and states that “*it is important to maintain your credibility*” (8, par 25) but with whom, he did not elucidate. I sense David’s need to maintain his clinical status, maybe unconsciously acting strategically to maintain the power/knowledge of the clinical field, but relational aspects are also discerned in his statements and I sensed he missed the camaraderie of the wards and theatres (8, par 64), although a comment suggests how the spirit of medicine may be ebbing; “*There’s the pride of practice issue, which tends to keep people on one place, but that’s not so important now either.*” (8, par 17) The inclusion of the term *either* suggests that there are other areas where the importance of the consultant has diminished.

David describes his job as if routine “... *making decisions, developing strategy*” and dealing with “*difficult doctors*” (8, par 44). This latter phrase implies that doctors may be considered the *villains* of the organisation (Davies, Mannion and Marshall, 2001) or that decisions are not always be amenable to all his clinical colleagues. This is evidently where David’s power/knowledge comes into play, subjectively able to see both sides of the coin. David is able to place himself as the authority of delimitation between the service commissioners and the consultants; “*there’s a responsibility to use NHS resources wisely and how do you deal with consultants who want to carry galloping along...?*” (8, par 48). Of course, the definition of the term *wisely* is open to interpretation and a consultant’s perspective of what is *wise* may not resonate with limiting funding for patients who need treatment.

David’s status and enunciative role for both the Trust and the consultants is explicit in his interview, but I feel that he begrudges the introduction of the ‘professional’ manager into the NHS and his statement that; “*the hospital administrators were just that, weren’t they? It was effectively the consultant body, in some form, that controlled the show*” (8, par 84) support the thoughts of Harrison, Hunter and Pollitt, (1990) and Hunter (2002). Clearly recognising the loss of medical power, David’s strategy is to address this subjugation by

emancipating the consultant voice in the field of management; thus reinstating the norms of a clinical discourse.

*“The thrust, of course, is to get more doctors involved in management and to be appointing doctors, or more importantly clinicians as Chief Executives. That strategy has not been very successful...”* (8, par 175) and later laughingly reiterates this point; *“...there’s got to be more doctors in charge, definitely”* (8, par 183), but explains that the *political pressures* (8, par 175) on Chief Executives makes the role unattractive compared to the consultant role. David’s narrative supports Hallier and Forbes’ (2005) belief that involving doctors in management can remove the delineation between the clinical and managerial discourse and can resurface the patient focus, reduce risk and improve clinical outcomes, *“which would permeate the whole organisation”* (8, par 179). I ponder whether politicians are very aware of how the Chief Executive role does not appeal to Consultants, who would much rather stay in their *protected* comfort zone (8: par 80) that Sutherland and Dawson (1998) recognised; in effect they exclude themselves from the dialogue and by doing relinquish the strategic ability to perturb the system and modify the governing discourse.

### **Summary**

These eight vignettes provide an ontological perspective of the organisation as constituted at the micro-level through the polyphonic nature of diverse agents where although each agent relates similar events and dilemmas each does so through a unique lens. As a ‘Foucauldian CES’ would suggest, a patterning of common themes is emanating and is discussed in more depth presently, but the inter-discursive impact of clinical, political and managerial discourses in the habitus of each agent is revealed and performative dominance is witnessed in the entrenchment of the term of *delay* in every respondents account.

From the outset my interviews show how the dominance of performative privilege appears to be generating frustration and anxiety in the everyday practice, especially of the ‘active’ clinicians, who challenge this discursive closure by attempting to draw boundaries around their world and by resurfacing

their own archival knowledge as a means to breach the marginalisation of their discourse.

### Exploring Corporate Discourse - *The Magnificent Seven*

The Trust Board minutes, although diplomatically vague, do provide a flavour of what is considered of strategic importance within the corporate levels of the secondary care context. I retrospectively start my analysis, following the completion of the interviews to avoid my self from being ‘polluted’ by certain events. I review twelve months data, covering the data collection period and the preceding six months.

Exemplifying rational strategic management the Trust Board epitomises the ‘top management team’ and actually call themselves the *top team* (06-07) embodying the ‘thinking’ level of the organisation, whose bureaucratic powers are mandated by the endorsement of frameworks and the application of the *common seal* (03-07; 04-07) to organisational policies. The minutes also differentiate, in the attendance list, management from staff representatives, whom, I assume, represent the ‘doing’ level of the organisation. The rational strategic management philosophy is enforced from a political surface by a report (NHS Wales, 2007) that impresses the need to “*articulate, own and embed a strategic vision for the future*” (10-07) and the minutes do not disclose any reticence to follow this line.

The monthly Board meeting is a coming together of the diverse authorities of delimitation in the health care eco-system, comprising primary care, secondary care and public representatives, each enunciating their own perspectives with regard to performance, financial and clinical issues. However, although partnership working is promoted by the WAG, it appears that those who speak for the social services sector are not easy to engage (01-07). This concern is repeated (06-07) as a risk to the success of the *Programme for Health Service Improvement* and voices the need to “*capture the hearts and minds of those working in the relevant organisations*” (06-07).

The meeting begins with minutiae, such as retirements, impacts of new legislation, and celebrating successes, such as the opening of new units or transfers of services. I note how success in surgery and midwifery services resonates with the de-professionalisation of services, by devolving control to nurse-led units. The minutes follow a regular pattern that aligns with a performative and surveillance discourse as meetings describe the need to implement political requirements as stipulated by documents, such as the *NHS Wales Annual Operating Framework*, the *National Standards of Cleanliness*, *Modernising Medical Careers* and *Welsh Risk Management Standards* together with recommendations generated by centralised surveillance bodies, such as *Health Inspectorate Wales*, the *Auditor General*, *Wales Audit Office*, the *Institute of Health Improvement* and the *Health Foundation*.

The substance of the meeting revolves around issues of capacity and increasing demand, the meeting of *Service and Financial Framework* (SaFF) performance targets, the imposed *Cost Reduction Programme*, financial concerns, staff absenteeism and clinical governance. The minutes cite political interventions, such as *Improvement By Design* (07-07) and the *Safer Patient Initiatives* (04-07) and linear approaches to service delivery such as *care pathways* (07-07). Throughout the minutes I note the excessive use of ‘management speak’ and convoluted expressions, such as *workforce health* (02-07) and *adverse variance* (01-07). I do not know if this is to deliberately bewilder, especially the lay and ‘staff’ members, a particular form of impression management, a way to cloud the significance of certain realities, especially that of bad news or simply an attempt to be politically correct.

### **The Chief Executive’s Report - *Nero***

I apologise for the derogatory metaphor, *Nero*, but narratives of my participants stain my thoughts. In reality the Trust is not the instigator of reform, but the mere implementers of political intervention and the Chief Executive relates the need to deal with the prescriptions of political discourse, such as, the “*Incentive and Sanctions Framework for NHS Wales*” (NHS Wales, 2007) (11-07), a document that reverberates with punitive tones; the *Emergency Unit Action Plan*

(11-07), a plan to address pressures in the Emergency Unit following adverse media coverage, and the *Healthcare Inspectorate Review* (01-07).

Primacy is given to the introduction of two specific political discourses that define a particular perspective of secondary care as clinically failing and unsafe, the *Patient Safety Initiative* (SPI) and inefficient, *Improvement By Design* (IBD). The minutes suggest how infection rate targets are to be addressed by a *Patient Champion*, a board member, *tasked to bring issues and practices associated with hygiene, cleanliness and infection... to the notice of the board* (10-07) and may have been catalysed by the high profile events in Maidstone and Tunbridge Wells NHS Trust (Health Commission, 2007) where the chairman had resigned because of the failure to prioritise infection control.

IBD is to be undertaken by external management consultants and although the minutes do not offer any detail they stress that the initiative is “*not just about money, but ensuring a more efficient service was provided in order to improve patient care*” (07-07). The tool-based mindset of SPI orients around linear and mechanistic approaches to improving cleanliness through the use of *daily goal sheets for patients* (04-07) *Safety walk rounds* by the Chief Executive to *improve communication with staff* (04-07; 05-07; 06-07), a *rapid response team* to deal with deteriorating patients (10-07), *safety briefing meetings* (11-07), *plans for hand hygiene* (11-07) and a *Safety Culture* survey (12-07).

### **The Review of Performance Management - *Chariots of Fire***

As if to highlight its importance the report on Performance Management always follows the Chief Executive’s report and summarises the extent to which the Trust is meeting its set Key Performance Indicators (KPI), such as targets for waiting times for elective surgery and cardiac surgery, cancer care, out-patient waiting times, emergency waiting times, day case rates, delayed transfers of care, cancelled operations and complaints.

The year, 2007, opens with the Trust in an *adverse position* but is; *making good progress* by identifying *hot spots* and supports the heroic view of managers as; *the appropriate management action was being taken where plans were in place*

to meet targets by the end of the year. (01-07). Mention is also made of the use of *Second Offer* to meet elective surgery targets, (03-07) although the Director responds that *the sustainability of complying with these targets was a challenge* (01-07) although by the end of the year; *targets had been achieved, but under difficult circumstances* (04-07). As the following year progresses the minutes suggest that the pressure surrounding the achievement of targets is reduced, but new KPI are introduced and the initiative “*Improving By Design*” is one of the tools aiming to address these needs (05-07).

A major concern, raised on a monthly basis, is ‘*delayed transfers of care*’, a situation where patients medically fit for discharge are blocking beds due to lack of accommodation in the community. These delays are leading to *bed pressures* (02-07) and I construe that acute patients are blocking elective beds and necessitating the need to cancel operations. The February meeting appears more animated about the need to consider options on how to ‘release’ these beds although I note that any decision on the viability of each option is deferred to another meeting, perhaps behind closed doors. It is clear that some of the options would draw increased costs, but I imagine this would need to be balanced with the risk to the Trust, rather than patients, of not meeting targets.

### **The Financial Report - *A Fistful of Dollars***

The financial position is another significant aspect of the meeting where the extent of *adverse variance* is announced monthly, generating the need to utilise contingency reserves (04-07). Sound reasons are provided for deficits and include increased nursing expenditure, the need to open ‘un-commissioned’ beds to combat increasing demands and over-performance, although the *adverse variance* diminishes with the approach of the end of the financial year and the Director is confident that; “*the Trust would achieve it’s forecast balanced financial position by the year end*” (01-07).

The Trust’s progress on meeting the government’s Cost Reduction Programme (CRP) is also voiced with the same confidence (01-07) and February’s meeting suggests a surplus that would *allow for some coverage for delegated budgets* (03-07) which were in deficit. The Director (02-07; 03-07) reveals how advice

from independent management consultants would be sought with regard to making efficiency savings in particular clinical areas.

The Director's desire to meet sickness targets is to minimise the use of locum and agency staffing, but the Director understands that meeting the sickness target; "*was not entirely within the gift of managers*" and that as such "*targets were breached with good reason, it would be wrong to penalise the budget holder*" (03-07) thereby dismissing the effectiveness of any likely disciplinary action and suggests that any 'wellness' agenda as Costea, Crump and Amiridis (2008) would support, has economic rather than socio-centric underpinnings.

In allegiance with the minutes, I am also relieved to note that; "*the Trust had no debts...and was now in a strong position to make further improvements...and had been able to incentivise efficiency by investing in priority areas*" (05-07). However, it is noted that the vicious cycle of adverse variance starts again in the new financial year (07-07) and concern is again noted regarding the embargo on employing agency staff (09-07).

### **The Human Resource (HR) Director Report - *In Sickness and In Health***

The HR Director's report is largely concerned with the monthly progress, or lack of progress, with the transfer to the *Agenda for Change* pay banding framework, the associated *Knowledge and Skills Framework* competencies framework and the *Electronic Staff Record* (ESR). These benchmarked internal processes each facilitate increased staff surveillance from diverse and prescribed performative angles and the compliance of the Trust with specific and targeted normalisation in comparison to other Trusts across Wales. As a discourse of surveillance, it is not merely auditing individual staff performance against such targets but of the comparison of the Trust itself with 'best' performers, regardless of contextual differences that might arise in Wales.

Akin to the Finance Director, the minutes reveal the HR concern for staff *absenteeism*, which I infer means 'sickness', and the need to improve the number of *absence forms* returned to HR, a theme that continues throughout the year and suggests a two-tier discourse of surveillance of both managers and staff, as forms are not being completed as expected, suggesting a degree of

resistance from departmental managers. Every month records an ongoing saga of *workforce health*, but access to workforce statistics deteriorates further with comments about the malfunctioning of the ESR (02-07) and the validity of the *sickness/workforce health* data (02-07). The term *workforce health* resonates with a HR discourse of staff *wellness* (Costea, Crump and Amiridis, 2008); a way to utilise sickness records to ideologically govern the self with an imagery of *total well-being at work* (2008: 670).

The HR Director discusses the *Strategy for Life Long Learning and Workforce Development* (03-07) which in the true spirit of rationalism presents a framework for achieving organisational excellence, based on team based working, as if this is a novel idea, management and leadership development and competency-based training programmes. The need for a collaborative environment to share and capture knowledge reinforces knowledge and commitment based discourses (Costea, Crump and Amiridis, 2008) as the means to functionally engineer agents to foster innovation.

May introduces the *Designed to Work* (05-07; WAG, 2006c), recognised in chapter two, as surfacing from the political surface of health care. The title reflects a systems approach to the functional needs of the organisation and prescribes the rational means to “*create new roles and develop new ways of working*” (2006c: 2) in way that mimics the principles of scientific management. I reflect on Jacob’s (1961) comments that modernism aims to design in what it thinks an organisation needs to flourish.

### **The Director of Nursing Report - *Ooo Matron!***

In comparison to the other areas discussed, this part of the minutes appears comparatively short and relates mainly to staffing problems and risk aversion techniques using specifically designed tools and initiatives, such as the *Safer Patient Initiative (SPI)* (02-07; 03-07; 04-07), the *Fundamentals of Care* (07-07) strategy, the *Cleaning Strategy*; a plan of action to achieve the targets for infection control (01-07) and the *Dignity in Care* action plan (11-07); rational tools and plans that I would expect to abound in an environment of managerialism.



The need to employ temporary and agency nursing staff is a continuing theme that mirrors the concerns of the Financial Report, but the Nurse Director adds a patient centric and clinical perspective to the economic concerns by stating that; *there are clinical risks with using temporary staff* (09-07). The need to employ agency staff is the consequence of a reduction of overtime payments for permanent staff and is attributed to the Trust's *obligation to implement the new [government] framework* for permanent staff and implies an economic imperative. The term obligation suggests accountability and I am beginning to recognise a cycle of diminishing returns where one intervention seems to generate a deprecating and non-linear effect on another.

The Director's involvement in the national *Standards of Cleanliness for NHS Trusts in Wales* (WAG, 2003) superficially depicts a clinical discourse that advocates performativity and accountability and generates the rational processes of SWOT analysis, an ensuing action plan and a *champion*. With regard to risk management, however, I am concerned to note, especially with regards to my previous research into clinical failure, about the shift from a "*no blame culture*" to a "*fair blame culture, which would be linked with staff competency...*" (09-07). I ponder of the definition of *fair* and what this bodes for transparency and relations of trust.

There is also discussion surrounding the report entitled *Fundamentals of Care* (WAG, 2003) a guidance document for health and social care staff, a document noted in chapter two, that reduces the aspects of caring into twelve tangible dimensions that can be audited and clearly endorses the Trust's allegiance to processes of scientific management and surveillance (01-07).

In the discussion surrounding the management of complaints and adherence with the response target my interest is raised by a comment that suggests that such information should in future *be a discrete item on the agenda* (06-07) and I did wonder how many items discussed are considered too sensitive for the public's eyes. It may suggest why there is no evidence of Mary's reflection.

### **The Medical Directors Report - *Doctor in Charge***

I sense that the Medical Director's Report, like nursing, is fairly low key and mainly revolves around monthly responses to clinical complaints and queries, new appointments, resignations and business cases for new consultant posts, compliance with targets, updates about the symptoms of MMC and the new recruitment process for junior doctors. The Director also discusses breaches from care pathways; care pathways are linear processes of care for certain medical conditions that tend to systematise patient care with the aim of minimising variability in treatment.

Resembling the Nurse Director's Report, the medical world appears bureaucratised and mechanistic in its approach to service delivery. In this regard, an interesting discussion surrounding adverse clinical events in surgery states that; "*staff did not feel empowered to raise concerns [about processes]*". The Board's response considers that; "*a cultural change was needed to facilitate this [their input]*" (12-07) reinforcing the need to engineer behaviour, implying that the current 'culture' of the workforce is to blame, rather than the management approach.

Another instance, with regard to the *behaviour of some medical staff* (05-07) implies consultant resistance for the new recruitment process, where discussions are to be continued after the meeting, again reflecting that the 'airing dirty laundry in public' is suppressed and may suggest that the genuine complaints of medical staff are stifled or silenced. As a final comment, I must add that discussion on medical teaching and medical research appear low key and gives me the impression that these necessities are a subjugated activity in the Trust's performative environment.

### **The Reports of the Sub- Committees – *Trains, Planes and Automobiles***

The Board meeting closes with reports from several sub-committees that promote a surveillance function, and include Performance and Use of Resources, Audit, Clinical Governance, Charitable Funds, Risk Management, Research Governance and Human Resources. The Clinical Governance and Risk Management committees raise the most significant issues for this thesis and

their surveillance function is clear through consultant appraisal systems (09-07) and the maintenance of a *risk register* (10-07). The task and procedure-based thinking of scientific management is evident in policies such as, *Pressure Ulcer Risk Assessment: Prevention and Treatment* (0207).

However, a statement inferring the stagnation of practice is raised suggesting; “*the Clinical Governance Committee and its associated machinery [becomes] more proactive*” (03-07) and the use of the term *machinery* is significant in its association with the proliferating chains of bureaucracy. The minutes further display how an ideological approach to staff well-being, is being embedded through the *Health and Safety at Work Policy*, *the Personal Safety Policy*, *the Lone Worker Policy* and *the First Aid at Work Policy* (03-07).

### **Summary**

Although this section represents only a brief analysis of the major debates of the Trust Board, I attempt to capture the areas that are most significant for my later discussions. Although difficult to discern, the dynamics of the minutes do appear to change, where meeting targets by the end of the fiscal year is a clear imperative from January to March from whence the focus starts moving towards clinical focus, in particular the discourse relating to risk and safety.

The minutes present the impact of the political surface of emergence and it is evident how the political discourses of performance management and clinical governance concurrently endorse the governance of clinical and management activities. The rational and risk-averse nature of political discourse is clearly mooted through an almost obscene number of policies and tool based initiatives, that attempt discursive closure and reflect what Foucault (1980a) would recognise as a corpora of documents that align with a rational and scientific discourse, the impact of many I will doubtless perceive as I explore the everyday experiences of my respondents.

### **The Inter-Discursive Tangle of Health Care Reality - *Body and Soul***

The following section depicts an in-depth exploré of specific themes through the multiple voices of my respondents and allows me to contemplate how an agent’s

self deals with the truth claims of statements that cross their habitus. As Baskin (2008) contends I experience their unique perspectives and through this experience attempt to interpret their version of reality, the inter-discursivity of their selves and the extent to which their self is in allegiance or conflict with the dominant statements of governance; their accounts do not mirror reality as much as construct it (Miller, 2006).

However, the reader does not only here my voice in this section but the voice of my respondents as I allow them, on occasion, to speak for themselves. This emancipates their heterogeneous claims without any interference from my own 'will to truth' so that as the reader you may connect personally with each agent and experience how the seemingly rational aspects of day to lives are filled with conscious and unconscious desires, anxieties and emotions.

#### **The Impact of Political Discourse – *On Her Majesty's Secret Service***

My earlier chapters elaborate how the discursive impacts on the secondary care field are many and varied, but my analytic of power in the NHS suggests that health care is being pursued in a pincer movement by two external discursive unities, managerialism and clinical governance, that emerge from a political surface of emergence, their grid lines of specification converging to unify a body of modernist knowledge. One movement relates to the quality aspects of service delivery the other to the efficiency of service delivery. I leave intact my unconscious, but spontaneous choice of the negative metaphors, pursue and pincer movement, as this accentuates the bias of my own self and leaves you as the reader to establish your own opinions of my analysis.

#### **Targets and the Treasury – *For a Few Dollars More***

The non-linear effect of political discourse in the working lives of all of my respondents is clearly articulated and yet each voice offers differing perspectives as to its impact on their everyday practice. At the strategic level, David is caught in the economic struggle of the internal market; "*There's only a certain amount of money to go around and if the commissioner...says 'this is all we can afford' ...it's ultimately their decision and ...we must implement it*" (8, par 56). We might recognise how balancing the fiscal equation is clearly borne out

month on month in the Trust Board minutes and requires a fine balancing act in line with the *cost reduction programme* (01-07). Whilst the subtext of David's account implies that 'it's not my fault', the evidence suggests that the WAG give with one hand and take away with another.

Although the weight of the commissioner's power is mandated, David's addition, "*we must argue against it if we feel that way*" (8, par 56) implies some degree of clinical resistance. The 'we' seems to reflect the consultant voice, whom he suggests "*are very savvy...because the commissioners are not in a good position to counteract tales of patients dying or coming to harm because they can't be treated*" (8, par 64). David's statement strengthens the academic view that doctors and managers potentially disagree and challenge the decisions about what should be prioritised (Baker, 2000; Garvin, 2004; Hallier and Forbes, 2005; Harrisson and Lim, 2003; Hunter, 2002; Kowalczyk, 2002; Plochg and Klazinga, 2005; Som, 2005). David explains however, that; "*most clinical staff know why a target is imposed, but don't agree with it because it skews resources*" (8, par 303) and questions, "*whose decision is it what the targets are?*" (8, par 303). David's tactical thinking ponders; "*Is there money elsewhere in the Trust, in other services, that we can move across, or restrict services that aren't so critical*" (8; par 56). The question that arises is critical for whom.

With regard to the relations of power between the Trust, the consultants and their commissioning 'partners', Liam's narrative signifies the delineation and emphasises the marginalisation of the clinician voice.

*"As non-commissioners we're only able to put forward our views, and we're not actually able to lead the services in the ways that we would like to. We can see ways which we would want to go forwards, but if they do not align with our commissioning partners, then we can only give those views to them, and that's a real challenge because you then feel that sometimes you're being asked to deliver care that you don't view as being the optimum, and you don't view as being the right direction...it [the commissioning] does appear at odds with what I know as the scientific base of information, or is based upon highly selective*

*interpretation of smaller studies, where larger robust studies may actually point to the opposite way, so sometimes commissioners are seeking scientific advice, scientific information, and we're possibly not interpreting it in the way that may be most appropriate and that's a concern...I think we do have a good voice and we do have good lead communicators, and I don't think it's a failure to get the information over. It may be that sometimes that information is not what the commissioners want to hear, that sometimes it may be pushing in a direction that is not aligned with the policy... Some of the difficulties we've had recently probably relate more to attempts to engage and they have engaged a group of clinicians with a bias one way or another, because we'll all read those papers, and we may come to different outcomes, so when commissioners go and ask, it depends who they ask, to a degree" (7, par 56- 67).*

Liam's narrative powerfully mirrors the Keynesian quote that "*there is nothing a government hates more than to be well-informed*" (Keynes, unknown) and supports Dacre's (2008) assertion that the medical voice is marginalized, even though it is deemed essential for successful reform (Dacre, 2008; Edwards *et al*, 2003; Thorne, 1997). The indication is that knowledge may be manipulated to exclude certain perspectives of service delivery by (in)validating or interpreting a particular body of knowledge to verify a particular strategic direction.

Moving into the operational level of service delivery, the prescriptive impact of political discourse begins with Liz's criticism of the Unified Assessment (UA) process which she clearly associates with direct political intervention: "*a rather frustrating tool which was brought in by the Welsh Assembly, but we are doing the best we can with it*" (1, par 128). With regard to UA, concerns are also raised by other respondents (3, par 60- 68; 7, par 204) who argue that this process is systematically completed for "*any patient if there is any hint of them needing continuing care*" (1: par 103). The respondent's descriptions of UA reflects a rational and linear document that diminishes informal verbal communication between the two public service sectors, replacing this with formal documentation and delineating the discourse of caring into distinct types; social care and continuing care.

However it is the several stories by Mary and James relating to delayed transfers of care that begin to elaborate on political intervention at length. Mary seemingly plucks the issue of *delayed transfers* from the air, as a mere story to explain how nurses need good social skills (2, par 8) but what becomes quickly apparent is that discharging patients **is** the issue and I cannot fathom whether UA is a symptom, solution or a cause of delayed discharges, but delays in patient throughput is a recurrent and verbose theme in every interview.

One of James' major concerns is meeting the *four hour trolley waits in Accident in Emergency* and the *length of stay targets*; (3, pars 605, 995, 1003, 1066, 1149) and his anxiety is encapsulated in stories that fluctuate between accelerating the discharge process and admission avoidance, which in lay terms is directed at stopping people actually being admitted to acute care. It would seem ironic that you would want to stop people coming in who are acutely unwell as this would formulate a very odd definition of care, but as my interviews progress, each respondent relates stories that orientate around the difficulty of discharging patients once they are pronounced medically fit for discharge.

James favourite analogy was that of the digestive tract where patient throughput had become constipated in the middle. I winced, but got the message and James' plan is to avoid '*constipation*' (3, par 68) at any cost. It appears that political discourse, by defining two distinct definitions of care, health care and social care, and separating the funding that accompanies each definition, is forcing the organisation to close its boundaries in an attempt to stabilise in-put with out-put, by removing what for them is perturbation from another system; patients.

All clinicians' and managers' interviews relate their experiences of dealing with delayed discharges. The repeatability of this sentiment is profound in suggesting how a performative perspective has modified the rules or normative logic of our agents' habitus. None are so passionate, in this respect, as James and this narrative frames the brunt of his critique; "*... in Wales, allegedly, is a very unique Minister we have who has Health and Social Care under one umbrella, but I think that umbrella starts and finishes in that person...we on the*

*operational level, are very much apart” (3, par 34). James is derisive about the political rhetoric that promotes working in partnership with social services when budgets are split.*

*“I believe in working beyond boundaries and I’ll do anything for anyone...who are you working for? That patient, and if I have treated this patient and the next phase of this patient is to just safely transfer this patient home and provide a safer environment, then when Government and big Ministers and all these Chief Exec of big organisations say “Why not, what’s stopping us?” Instead of saying; “You pay for it or I’ll pay for it, it’s Continuing Care, or this care, or that care”, every year if it’s a Social and Health Minister, then it’s not going to be Social and Health funds” (3, par 905).*

James is irritated that the process of discharge, on which the success of his role depends, is constrained by arguments about which sector is going to fund continuing care. The non-linear symptom of this delineation in the caring discourse resonates throughout the whole Trust as ‘delayed transfers of care’ and the Trust Board minutes validate this ‘hot topic’ in every meeting.

The political intrigue deepens as James proffers a very significant narrative that indicates how political discourse engenders a mode of surveillance in the NHS sector that social services do not experience to the same degree; performance targets; *“our trolley time is four hours in A&E, our bed time is eight hours in MAU, Social Services target to come and see the patient is two weeks, and prepare the case for two weeks. So if you really think about it, this patient is medically fit **now** and they have one month to prepare the case” (3, par 991).*

What is further confounding the process is the existence of a backlog of patients waiting to be seen by social services (3, par 991) and lack of authority of social care staff working at the clinical level; *“This Social Worker has to go back and present the case to the Panel who said, “Oh, very little evidence.” The patient sits [in hospital bed]...if the Social Worker is making an assessment,... is following all the Guidelines there is to follow and presents the case to a Panel*



and the Panel says “Not enough evidence”...they are questioning their own representatives...” (3, par 838).

The symptomatic knock on effect of fractured funding is further addressed by Jo who, as an intermediate care manager, has first hand knowledge of the *greyness* (6, par 174) of the continuing care process with regard to matching patients against the criteria for funding, because “*their [social services] budget is overspent*” (6: par 218). Jo, however, provides a heart-warming story, which explains her need for keen negotiating and inter-relational skills. It indicates how informal and perhaps shadow, connectivity can build a bridge across the political chasm, but her underlying narrative indicates a self concerned for the patient caught in gap between health and social care (6, par 246-254).

The ability of the system to co-evolve is blocked by delineation between health and social care, underpinned by their fiscal arrangements. Jo needs to be adaptive in such a context and her newly found autonomy suggests she is *setting the precedents* (6, par 258) by transgressing the boundaries to engender co-evolution between two delineated sectors by increasing connectivity and inter-relational working.

Within these interviews, several comments clarify how the system could be improved by “*the Trust hold[ing] the social care budget* (8, par 221) or that wards employ their own social workers (6, par 158) so *they [the social workers] learn their way around the two systems*” (6, par 330) but I sense their thoughts are marginalized or that they are not allowed the social platform to speak. Ideas conjoin the two systems allowing them to co-evolve by providing the autonomy to self-organise and Liam explains where this has worked off-site; “*it makes a huge difference*” (7, par 203).

The narratives indicate how political discourse engenders two authorities of delimitation from acute medicine and social services, each with its own autonomy within its own context, but where the power relations are unbalanced. As Foucault (1980a) suggests each side seem to retreat to reorganise its forces,

by creating ‘delaying tactics’ in social services and admission avoidance in acute care; the battle continues, but the Trust is left ‘holding the baby’.

What is irrational is that this conflict is counter-intuitive to the government rhetoric that advocates ‘partnership working’ by a fiscal model that entrenches difference between two contextual definitions of care. Two distinct discourses exist, each resonating with a discourse of caring and the notion of well-being, but are simultaneously divergent creating two distinct domains of practice, because of their funding arrangements. Whilst each domain will attempt to fix their definitions of caring and inclusively mandate their own authority in the field, what is more confusing is that ultimately they both appear to have a mutual authority of delimitation and a common surface of emergence, the Minister for Health and Social Care.

### **Public Scrutiny or Political Voice –*The English Patient***

As my interviews gather, stories reveal a new strand of power/knowledge vested in a discourse that emerges from the wider eco-system, an unexpected authority of delimitation, the public, or more accurately those that position themselves as advocates for the public and patients, the Community Health Council (CHC). This should not have been a surprise for me, after all the WAG (2004; 2007a) do advocate *democratic engagement* (2007a: 8) in health care, but the inter-discursive impact is greater than I imagined and it was remiss of me not to recognise this in chapter two as stories offer a fascinating and significant diversion.

The CHC (2007) describe themselves as health care watchdogs, who undertake monitoring visits and public consultations with the aim of improving the quality of local health care services. Of further intrigue is that they state they are a *statutory and independent voice* (CHC, 2007) and in my first interview I came metaphorically, face to face with power of the CHC who had arrived, without notice, to conduct ward inspections (1, par 19-32).

The public voice became more a significant dynamic, as the CHC are also mentioned in the consultant’s (7, par 204), managers’ (5, pars 99, 119; 8, par

315) and ward sister's (2, par 78) interviews. I gain a cordial impression of the CHC (2, par 82), positioned as a patient advocate; *"their expertise is very patient focused and ...when it comes down to policy they are clearly somebody with a big interest and stake in it"* (7, par 82) and that as members of the Trust Board they are *"quite astute and understanding...they understand the issues ...and tend to work with us...they produce awkward questions for us but I wouldn't say there was any conflict, as such, not here anyway"* (8, par 315-331). However, an irruptive statement from Jane betrays her belief in the objectives and tactics of the CHC; *"well that's the theory... but they don't necessarily play the game..."* (5, par 70) explaining how the CHC use many different forums to raise the issues of variations in treatment and patient dignity over and over again.

Jane's story about a CHC request to talk to in-patients suggests a disruptive influence (5, par 147). *"The CHC wanted to talk to outliers, if things go wrong you can guarantee its going to be that person [the outlier] because there not getting all, they're not in the right environment ... "For what purpose?" "We want to know what they feel about it", "Well you know what they feel about it; they're not on the right ward"* (5, par 119). Jane is careful with her terminology; understanding that patient safety is paramount, but what is evident is how the Trust is being forced into position of defence, having to explain the rationale behind ward closures and inconsistencies, in the face of what appears as a very powerful body.

Jane acts as an enunciative modality for the Trust, clearing recognising the Chief Executive as an authority of delimitation; she retreats and retaliates by gathering the knowledge to deflect the power of the CHC discourse. I use the word retaliate deliberately to emphasise the dichotomous ontology, the 'them and us' dialectic that evokes thoughts of a combat zone; a perspective of the CHC that the other interviews did not reveal. Jane's self is recognising a different dimension of the CHC, one that causes perturbation through monitoring visits, enunciative acts of surveillance that breach the barriers that attempt to maintain stability and credibility, provoking the type of defensive behaviour that thwarts

collaboration, engendering a loss of the trusting inter-relations and reciprocity that co-evolutionary environments require.

I do not make any judgements on the values of the CHC, but reveal how the acts of the CHC are an exercise of political power, they are a political device, a political discourse of surveillance, shrouded in the notion of protecting the quality of service provision through a third party. Supposedly independent, their discourse of surveillance, although superficially appearing to exist in parallel, promotes powers that are inter-dependent with a political discourse of surveillance, but one that simultaneously runs counter to a political discourse that privileges an economic focus.

Whilst the economic priorities of the Assembly are reducing health care budgets massively, they are enabling their own policies and frameworks by devolving statutory responsibility for quality to the CHC; the grids of specification cross, providing the Assembly with a covert means to exercise power from an opposing direction. The Trust is sandwiched between a political and public discourse. Whether one believes this ‘independent’ monitoring body is virtuous or not, what is generated in the Trust is a huge bureaucratic machinery of red tape and documentation (5, par 48- 72, 119; 147) that unarguably echoes the mechanisms that engender the obedience of docile body (Foucault, 1977). What is almost ironic is that the Trust publishes an annual report on the number of complaints to the Assembly; complaints that in some instances are being raised by the public body that the Assembly set up; a true act of humiliation.

My interpretation is further bolstered that any genuine power of the public voice is restricted and that their views are not always sought at the strategic level (8, par 303) or at the commissioning level; *“It is unlikely that any commissioner is going to be able to talk to everybody...you’ve got to be pragmatic about that. Sometimes I think there’s disappointment where some of the [voluntary] organisation isn’t approached...it’s a little frustrating that there is a group of skilled, enthusiastic group that they are not actually contacted and engaged and I think that’s sad...Unfortunately, sometimes those groups when they do sit down have conflicting views of how to deliver what most of us want”* (7, par 74).

Liam appears to be describing Bourdieu's (1991) thoughts on how the entry to the decision making fields is constrained by political authority, marginalizing the public voice and turning them into passive agents.

To contrast this marginalisation, Jo's comments reflect the power of the patient voice; *"people think that they are going to come into hospital and be made better, well, you can't make somebody better who couldn't walk before and that as basic as that, people don't seem to have that explained to them"* (6, par 278). A senior manager reinforces this message: *"the message is coming from Government that the NHS is hunky dory and you'll get excellent treatment wherever you are...you shouldn't tolerate any delays or any inefficiency and, by the way, you certainly shouldn't get MRSA or die when you're in hospital."* (8, par 303). Others make similarly dramatic comments regarding the 'threat' of media intervention (6, par 266); *"They [the media] complain to say; "she died at the hospital with the Super-bug"* (3, par 605). Although the latter comments sound insensitive, they hammer home a message that reflects Baker's (2000) comment that political discourse is vocalising some idealistic guarantee of success and fuelling the fire of public dissent; the NHS; *"no longer tolerate[s] failure, but celebrate[s] success"* (Baker, 2000:140).

### **The Marginalisation of the Management Voice – *The Whisperers***

The functional role of Trust managers has already been exposed by the Medical Director (8, par 56) and Mary's (2, par 161) interview and my exchange with Patrick adds to this perspective during a story about the problematic of the centralisation-decentralisation balance. Patrick argues for the future need to centralise particular specialist services across Wales; *"there are services here that are barely sustainable...and arguably it doesn't make sense that we are trying to run two services...but the Trust structure does not necessarily help that process...Specialisation should be on a regional level because that has a knock on effect to the way we deliver services"* (4, par 291).

Adding my interest in a similar debate, Patrick reveals in no uncertain terms, the power of the political surface of emergence in health care discourse; *"that's been put on the back burner now politically, because its not been seen to be very*

*helpful to [another Trust] ...to take services out of [another Trust] and yet the evidence is you can only sustain one [unit] in Wales...but continuing with two is not helpful to anybody...you can't sustain two, but we are and we will"* (4; par 337- 341). Patrick appears genuinely frustrated about how political interference is disrupting a service, whom he describes as, trying to cope with the inherited problems generated by an earlier politically led managerialist discourse that; *"skewed the level of service provision across [the area]"* (4, par 310).

It appears that political rhetoric (Department of Health, 1997) expects NHS organisations to adopt a business-like strategy and the values of lean thinking, but is happy to silence such thoughts rather than lose political face with the voting public. This clearly evidences how the norms of commercialism do appear to conflict with the 'socialist' values of patient welfare (Blomquist, 2000). The WAG need to understand that values that aim to accommodate all, within an ever diminishing budget, is futile especially when their prescriptive plans run counter to socio-centric ideals (Mannion *et al*, 2005).

### **A Discourse of Litigation - *Catch 22***

Another unexpected discourse surfacing in James' interview and one that I have overlooked, is litigation, or as James' prefers *litigatory medicine* (3, par 76, 178). Jane's interview also mentions litigation (5, 237) and essentially her role orients around the power and popularity of patient litigation, a very persuasive discourse in relation to a clinicians' survival.

I allude to the clinical requirement to adhere to systematic national guidelines in my exploration of clinical governance, but what James refers to is the 'butterfly' or non-linear effect of national treatment and referral policies on the primary care sector, as James' considers this a major causative factor in the increase in referrals to secondary care, exacerbating admissions and compelling hospitals to accelerate their delivery of services. Changes in the General Medical Service contract (2006b) further aggravate this inter-discursive perturbation by allowing general practitioners to opt out of 'out of hours' service provision; locum general practitioners are less likely to have an in-depth knowledge of the patient's history and are more likely to refer to secondary care.

Although the prescribed systematisation of referral and treatment evokes once again the exercise of power as governmentality (Foucault, 1991), one should not look at national policies simply as a retrograde move, even though it reduces the autonomy of clinical judgement in the primary care field, it is a step that aims to secure the safety of patients by access to speedy diagnosis and treatment, especially where symptoms are non-specific. It appears the need is real, as Sanders (2007) states that delayed diagnosis and treatment is one of the commonest causes of litigation in primary care.

However, litigation aside, what my narrative is attempting to emphasise is the frailty of the boundaries we attempt to fix around our organisation; primary and secondary care discourses co-exist, but are constrained by the differentiation and the discursive closures that discourse generates. Whilst the move is afoot to enhance services in the primary care sector (WAG, 2005), and hence take the pressure off secondary care this adaptive tension is being nullified through both a litigatory discourse and governmental guidelines for referral. The guidelines might well provide guidelines for judicious referral, but the threat of litigation and possibly removal from the register is far more powerful in a GPs eyes.

### **Summary**

My analytic reveals a complex eco-systemic perspective of the health care environment and the multifarious inter-discursivity constituted by discourses emanating from several surfaces of emergence, some of which were unexpected. Of interest is that discourses, whilst seemingly legitimising opposing constructs, politically interlock, placing the Trust in a stalemate position, where action can only lead to a breach in one direction or another. This 'catch 22' situation is supported by the minutes, where fiscal constraints clearly perturb the dominant performative agenda and where commissioners exercise power through the exclusion of particular bodies of knowledge, consolidating their position of authority and marginalizing the managerial, clinical and public voice.

The functionality of managers is clearly referenced as implementers of political decisions and do not appear to have the freedom that the 'private sector' enjoys;

they are caught in a political command and control philosophy, which cascades throughout the secondary care system. Although my correspondents are truly diplomatic in recounting their experiences it appears that resistance is ineffective and politically dominant statements appear to generate tolerance, apathy and potentially a high degree of agent passivity.

### The Impact of the Discourse of Managerialism – *War Games*

The performative focus of Trust Board minutes orients the reality of my secondary care context with an image of inefficiency and failure in a way that supports the political definition. The perceived lack of challenge thus legitimates the Trust Board to implement political reform through a rational model of strategic management that employs discourses of surveillance and normative control. Hence I now explore the way in which my respondents practice is influenced by the dominant statements of managerialism and the modernist bodies of knowledge to which managerialism adheres.

### Chiefs and Indians - *The Towering Inferno*

Ontologically, what is apparent, as my interviews progress, is the portrayal of an organisation in dichotomous terms, echoing and reinforcing the ‘thinking-doing’ fracture of a rationally managed bureaucratic hierarchy. The ward manager and ward sister both relate stories where initiatives and tools are rationally imposed upon the operant levels (1, par 230; 2, par 112). Mary’s frustration at their powerlessness is evident throughout her interview suggesting; “*they dictate to us... there’s no opportunity for us to raise new ideas*” (2, par 132) and that “*it beggars belief sometimes that they make these decisions and they have no thought about coming down to ask us, how are we going to put this into practice*” (2, par 72). Mary finally declares; “*All I know is we’re there on the ward doing what we’re told, our voice is there but its not as big as it should be, not as loud as it should be, because we haven’t got time to be loud, we haven’t got time to argue back...we’ve just got to accept what there telling us and make the most of it...*” (2: par 247)

This lack of clinical level participation in the decision-making engenders non-linearity, as the consequences of a ward closure ripple through the day to day



activity, absurdly disrupting standardised procedures; *“the consultant came up to me and said “I need to bring this lady in, she needs [a special facility]” I said “ We haven’t got one anymore” so he was banging his fists on the desk saying “I need [a special facility]” and I was banging my fists saying “We haven’t got [one]” so he then asked me to lie.... I said I wasn’t happy to do that because it was putting patients and staff at risk and why should I lie for him... so again we are caught slap bang in the middle of it”*. Mary qualifies this; *“I mean he was smiling when he asked me, but that’s beside the point, he wanted me to manipulate the system to fit in one of his patients, but who am I manipulating the system for? Him or the patient and if it’s a patient why should I have to manipulate the system, the system should be there to protect the patient, and provide these facilities...so as nurses we’re caught in the middle”* (2, par 68).

As Mary continues it is clear her discursive practice emerges to tolerate this imposition (2, par 80), but her patience is tested further by stories relating the use of *tabards* when doing medication rounds (2; par 114) and the notion of *protected meal times* (2, pars 112-132) both of which exemplify the tool based mindset of managerialism and the top-down interference in ward activities. Mary is not passive however and provides a spirited resistance to their ideas; *“it’s just not practical... we’ll, get our thinking caps on, on the ward, now and come up with another idea”* (2, par 136) suggesting that ward practice will ultimately evolve, even though this may not follow the proposed model.

These stories demonstrate, not only the way in which managerialism treats agents as functional entities, but also how synthesising what seems a common sense idea into another context can neglect the contextual dimensions of acute care, they are reduced through rationalising processes, possibly sensitised by political policy (WAG, 2007) that highlights malnourished patients. Foucault (1980a) contends that, in response to a discourse that conflicts with the self, the self retreats and regroupes and this is exactly what Mary does when her managers attempts to marginalize her voice and ‘savoir’. Mary is clearly exercising power through agency and whilst this could be deemed productive in harmonising an approach that fits the context, the overriding tone is negative.

In Complexity terms, the power effects of managerialism have set up an ‘edge of chaos’ position, disturbing the equilibrium and thus stimulating adaptive behaviour. However this (in)action by Mary is only possible because Mary is willing to take a risk and this may or may not backfire. Whether the interventions are ludicrous or not, the underlying narrative suggests that Mary is astutely concerned about the impact of this intervention on patient care and her action to propose an alternative reinforces the patient centric dimensions of her hexis; she acts unknowingly as an authority of delimitation for a discourse of efficacy.

Liz counters the prescriptive approach to management suggesting that “*there ought to be a more bottom up approach... senior management actually talking and listening to what we are doing already...and what we can realistically achieve,*” (1; par 314), but her statement expresses the Trust’s powerlessness by clarifying that these are WAG initiatives; “*its just thrown down to the Trusts and they have to implement it, so they [the managers] throw it down to us*” (1: par 314). The use of the metaphor *thrown* implies Liz’s belief in a total lack of regard for the people at the receiving end.

The Medical Director affirms that the discourse of rational strategic management cascades from the political level throughout the whole NHS system and whilst he suggests his role is; “*making decisions and developing strategy*” (8: par 44) he says of the commissioners; “*ultimately it’s their [the commissioners’] decision and if they’re prepared to back that decision ...we must implement it*” (8: par 56). David confirms this scenario; “*How do we deal with a commissioner that cannot afford to reimburse us for putting in, let’s say pace-making devices...we would have to restrict them [the operations] to 600 a year when we should be doing 1000 an year and how do you deal with that? ...How do you deal with the consultants who will want to carry on galloping along obviously*” (8: par 48)? In some ways the instrumental position of Medical Director reflects the ‘trustee’ (Foucault, 1977), persuading doctors, through an assumed allegiance with clinical level values, to conform to the decisions of Trust managers and commissioners.

The existence of an organisational hierarchy is portrayed in the nurses' stories, in particular, and their stories serve to reinforce this divide where managers and senior nurses are the dual authorities of delimitation. In terms of lines of communication both Liz and Mary state the need to *escalate issues up* the organisation (1; par 40). I love the term *issues*; it is so less damning than 'problems'. The use of 'we', 'them' and 'us' clearly mark out territory, differentiating between 'they' the managers and 'we' or 'us' the ward. Liz in particular suggests that *support from above... is sorely lacking* (1: par 37) and how the power of the ward manager is *twaddle* (1: par 36). Mary is cutting in her description of managers with their *fancy titled roles* (2: par 42) and the Chief Executive as; "*sat up there with all his managers below him, before he gets anywhere near us*" (2: par 68) signifying a belief in a web of management that stands ordinate to the nursing profession. This comment may elucidate David's story about the ward as a *comfort zone*, a zone of *protection* from the *outside world* (8; par 80).

Mary, in particular, voices her anxiety and frustration manifest by this shift of power and the need to cling on to an institutionalised position of power (2, par 321), perhaps suggestive of a professional voice that is being marginalized. It is reflective of Wright's (2004) debate on whether managerialism is burying the voice of the hospital matron. I can see why Jo is pleased to announce that her ability to act directly, by attending a meeting with the several senior managers, will "*skip that loop*" (6: par 113) in the chain of command. Jo had previously posited her narrative for her relief in being able to go straight to the top explaining that; "*... sometimes information doesn't go all the way up...so I think its middle managers responsible for that, because I think if you are a middle management you have your objectives, you are expected to achieve certain things, you've got your targets and so its not in your interest to escalate those things, because it appears you're not managing*" (6: par 101).

Another of Mary's stories cements the shifting authority and power relations vested in the hierarchical structure of the Trust, as she describes the 'new' voice of the Director of Nursing; "*we [the nurses] haven't got the voices to say that, whose voices should we be using, the Director of Nursing's voice? I mean, who*

*is she looking after? Is she looking after nurses or is she looking after the Trust. Is her role so broad that being director of nursing is nothing to do with nursing?"* (2: par 253). This statement signifies that political and economic surfaces of emergence are transforming the face of nursing and those who spoke on behalf of nursing, as authorities of delimitation, are perhaps being reconstituted by alternative discourses that embody non-clinical bodies of knowledge. The literature (RCN, 2006; Wright, 2004) is right to ask if the underpinning values of nursing have changed.

Mary's story about the Chief Executive's ward visit strengthens the power relations within the dichotomy further by exercising the power of hierarchical surveillance (Foucault, 1977, 1980a) through the gaze; *"We get a phone call, "The chief Executive is coming down, you've got two hours." "Two hours to do what?" "Well to tidy the ward." So the chief executive is coming down, what do we want a tidy ward for, this is as tidy as it gets, this is it, but no we run round like headless chickens putting everything tidy, hiding everything in the drawers, shutting things behind cupboards..."* (2, par 328). However, what is fascinating is that the story quickly diverges into another, as she describes when the [senior nurse] was leaving *"[she] turned around and said "What have you got over your uniform?" and I had white powder on my uniform from a glove and I said "oh I think its powder from a [glove]" and she said "try to look a bit more respectable next time." But I was just washing a patient when I got called away to walk around with these people..."* (2, par 332).

Although initially reluctant, this act to impress the management clearly marks out that Mary does feel responsible and accountable for the state of the ward, and 'obeys' accordingly, almost, as La Mettrie's concept of dressage would suggest; Mary is the docile body (Foucault, 1977) trained and shaped to obey and respond. However, Mary is upset at the lack of respect stemming from the denigrating comment of her nursing colleague, but the actual content of the comment is irrelevant, it is what the event signifies in terms of power that is important.

Rather than empathising with the challenges faced by contemporary nursing, her senior colleague simply de-motivates and subjugates Mary to a lower position on the hierarchical ladder of nursing, potentially reinforcing her own superiority and in some ways indicating an attempt to exercise 'sovereign' power through humiliation. Although Mary is amazed and angry at this interjection from a nursing colleague, it appears that she exhibits *self-mastery* (Foucault, 1985) moderating her own behaviour, refusing to challenge or resist. Mary's 'body' has become an object and target of power (Foucault, 1977) unaware that she reinforces her subjugated position as the victim of the encounter. The story also reveals a point Fletcher (1999) makes about relational behaviour where the agent willingly tries to minimise power relations through 'sacrifice' in order to save the 'project', which in this case, impressing the Chief Executive. As Herir et al (2006) suggest; *their mandarins say 'jump' and we say 'how high'* (2006:29).

### **Opposing the Normative Discourse of Managerialism - Tootsie**

My interview with Patrick, the general manager reveals an irruption to the overly top-down model described by my other respondents that suspends my obstinately cynical view of management. In some ways I am reassured as Patrick, like me, has come from the clinical field, an environment that, I believe, embeds a mutual respect for fellow clinicians, lending itself to interdependent working relations, that you ignore at your peril, although I am disappointed that this facilitating role had become separated and categorised as 'management', excluding the belief in the clinical level to work interdependently without assumed objective management intervention.

Patrick's account about his role proposes a relational discourse of communication and collaboration that is 'designed' to engender co-evolution between the clinical and non-clinical areas; "...by looking top down you could see across all the services and I could see we didn't make the best of the cross-linkages between all the services" (4, par 56). Although implying a position of management objectivity Patrick in reality is only speaking from his subjective perspective, from his interactive position in the net of relations. Whether Patrick truly sees this fracture for himself or has constructed this picture from

organisational stories matched with his own past experience is not clear, but the narrative suggests a degree of personal experience; *“What was happening in pharmacy was relatively independent to what was happening in radiology although ultimately we were all about getting patients through the system as quickly and as efficiently as possible, same with pathology, same with therapies, same with all services...”* (4, par 80)

Patrick’s statement implies that service departments depict ‘silo cultures.’ The term ‘silo culture’ is pervasive in the NHS and featured in my earlier research (Thomas and Matthews, 2006; Thomas, Liddle and Matthews, forthcoming), but it was negative image that I had resisted vigorously in my own mind, as my own experiences do not concur with this picture of self-interested isolation. Maybe the disseminated budgets of NPM actually created the silo effect, constructing barriers between specialities for, as David suggests, *“protection...a comfort zone...you know to the outside world, they’ll think they are completely undisturbed by it. You’re not really, but they think so”* (8, par 80).

However, again I am comforted as the narrative that follows Patrick’s account implies that the drift apart was intensified by the *changing ways wards were managed...it may sound incredibly old fashioned, you know the model of the ward and that sister in charge of the ward does seem to have changed their role quite significantly... and now we have individual nurses covering five or six patients rather than the team as a whole ward, the communication becomes quite difficult, because legitimately or not, nurses will say “well, I don’t know anything about that patient because he’s not mine”* (4, par 132).

Patrick continues; *“we’re trying to recreate that sense of ownership...the ward staff have got to recognise that cleaner is not just a skivvy...they’ve got to be welcomed as part of the team...its part of a process of making sure everyone who goes on the ward is clear how their role is contributing to patient care”* (4, par 136). The words *legitimately or not* are of interest here as he implies there has been an attitudinal change in the nursing profession and that *ownership* and *care* that once existed under the jurisdiction of the ward sister is lost. In considering Mary and Liz’s transcripts in particular, it appears that ownership

and authority has been stripped from nursing leaving them feeling unable to communicate laterally without hierarchical assent.

Attempting to disperse the boundaries, Patrick admits that clinical and non-clinical fields are quite different entities to manage and explains that because of staff turnover, flat management structures and the high number of generic staff in the non-clinical services, the change process is quick whereas he suggests that; *“in some of the professions it takes for ever to get a change in practice up and running”* (4, par 136). I was amused and a little embarrassed at what I considered a fairly accurate account of change management in the professional disciplines and wonder if this is a consequence of the power/knowledge discourse of the professional disciplines, the need to maintain their autonomy and authority within their field through resistive (in)action.

I recall the clichéd phrase ‘resistance to change’, but as Foucault would contend, their resistance is wrought through attempts to subjugate their referential knowledge and beliefs and hence power of their unity of discourse, their normative logic, in line with a conflicting perspective of reality. One may also expect that non-clinical staff are more likely to tolerate a form of ‘rational-legal authority’ and surveillance and operate resistance collectively through; *a higher level of Union activity* (4, par 136), although the high turnover rate, that Patrick mentions, may support Grey (2005) who contends that these *generic workers* are not the ‘docile bodies’ (Foucault, 1977) that they once were.

Patrick’s statements do not reflect any hint at subjugating or silencing the power/knowledge base of any field of practice, but enhancing it through collaboration; *“we’ve put a lot of effort into linking catering and dietetics and similarly cleaning staff and infection control...links were there in a tenuous way...and improving links with nursing staff because often the old operational services staff were not seen as part of the clinical team.”* (4, par 112). Patrick’s self is clearly influenced by a discourse that privileges efficiency, but practices his discursive influence in an organic manner, not by dictating or controlling but by engaging others in discussion. Hearing someone acknowledge the synergy of holism and collaboration between interdependent fields is music to my ears; it is

clear that Patrick is correlating an improvement in lateral communication of interdependent specialist staff, be they cleaners or consultants, with successful change.

To some extent, Patrick's narrative clarifies my confusion around the existence of 'silo cultures' and I think the moral to this tale is paramount as it beautifully demonstrates the existence of co-evolution. Pharmacy differentiates from other disciplines, such as biochemistry, radiology, haematology because it does not have a medical consultant lead. As Patrick suggests, these specialities "*are under the shadow of another group more powerful than they are*" (4, par 541). Patrick is alluding to the power of the medical profession.

The landscape of pharmacy has changed massively since I joined the profession and pharmacists have shifted the balance between their formulation role towards a clinical ward-based role and have intuitively buttressed this clinical role with, as expected, a higher educational qualification. Patrick explains; "*Pharmacy have been very good at cornering the market...and pharmacy took that opportunity...medical professionals have not taken the opportunities pharmacy did...they haven't moved out from what they were doing fundamentally, into influencing clinical care...and that's interesting*" (4, par 454-462). In retrospect, pharmacy's transformation emulates the phenomena of '*increasing returns*' (Arthur, 1990; 1995) where pharmacists accepted the challenge and have never looked back.

Patrick's narrative implies that departments with a medical lead have constructed boundaries; "*In [speciality] the [technician] is working for the [consultant]. To advance their own profession they have to get the acquiescence of the [consultant] who in some cases feel threatened. "That's my job!"...it's a real glass ceiling almost... "I could do that but that consultant does it and he's not willing to give it up"*" (4, par 486) As a pharmacist, it is perhaps now understandable why I could not see the silo culture that existed elsewhere, but this story demonstrates how the power effects of discursive practice are held with those who act and not necessarily with those who speak (Fox, 1997). Consultants are taking resistive action by drawing boundaries whereas



pharmacy, operating at a 'far from equilibrium' position, perturbed by the threat of losing their role took a risk and filled a gap in the service, there was no blueprint, clinical pharmacy emerged, it was not designed in, pharmacy self-organised and evolved into new ways of working.

### **Reconstituting Services through a Scientific Discourse - *Dr Jekyll and Mr Hyde***

Although Patrick exudes a style of management that recognises the relational aspects of management, his statements legitimise the performative discourse (4, par 164-168) and argues that *our* program of improvement will adopt *lean thinking* and *lean management* (4, par 164); "*they've looked at the flow of work ...to streamline it and...reshape it*" (4, par 168) and he is now "*convinced that we can take on more work if we adapt these ways of thinking...*" (4, par 168). Patrick uses the term *our* as if to generate a common organisational ethic or ideological commitment for the principles of lean working; that lean management is acting in a way to benefit all parties. I could perhaps at this stage refer to Foucault's (1977) 'trustee' role, where Patrick, as a respected clinician, is able to influence other clinicians with regard to a particular scientific 'ideology' and yet Patrick's self is revealed as fluctuating on a clinical-managerial continuum stating; "*the ultimate aim is impacting on mortality and morbidity...as well as keeping finances in order and the waiting time targets in order...*" (4, par 203-211). As Butler (1990) suggests Patrick's self is caught up in discursive influences of modernist management and its lean norms.

Other respondents reveal the entrenchment of the scientific doctrine of 'lean management'. Mary's account of her move to another ward, describes her old ward as; "*just filter[ing] patients through the system*" (2: par 29), but what is of interest is that Mary's self cannot deny the historical constitution of her self as she describes her new ward; "*it was like coming home, it was going back to nursing as I knew it, having patients in and seeing through the system, through their illness, through their problem to their final destination... that was, for me what nursing was all about, not just receiving them at the point of entry and shipping them on to the next available bed, but actually being with them through their highs, their lows and feeling some sort of reward at the end of it, it is the*

*job satisfaction of seeing a job completed...that is what nursing is all about”*  
(2, par 29).

This narrative defines not only the highly emotional and relational nature of caring, but the motivational factors associated with the job and supports the literature (Bradshaw, 1995; Gordon, 1991; Hay, 1994; Libster, 2000; Wright, 2004) by expressing that fragmenting patient care, in a scientific manner, may have negative consequences for both job preservation and patient satisfaction. I perceive an image of modernist intervention, confirmed by Patrick’s previous story, of the way in which nursing is fracturing its holistic view.

However, am I too quick in my judgement? Mary’s narrative may not just reflect a modernist intervention, to streamline processes for economic reasons, as I personally know that this can offer clinical advantages to the patient during the acute phase of treatment simply because health care skills and resources are concentrated in one place, easing communication and access to non-physical resources, like equipment; it may be scientific, but it may not necessarily be misplaced. However, I am haunted by Mary’s expression “*coming home*”; it makes me think that nursing is accommodating an evolution of caring that Mary is not totally comfortable with.

With regard to scientific management, one theme seems to reign supreme as mirrored in the Trust Board minutes, my polyphonic organisation is beginning to take on a fractal voice through the ‘issue’ of delayed transfers of care and multitude of ways in which delays affect every day practice, be it clinical practice or performance management. Mention has already been made in the Trust Board minutes regarding the knock on effect of delayed discharges on the financial situation and in compromising performance targets and the interviews recount how management interventions are approaching this dilemma through a linear, mechanistic manner.

In the first interview Liz’s tells of a lack of progress and perhaps, acceptance of *Protocol Led Discharge*, (1, par 72), a managerial intervention to delegate the responsibility for discharge from the consultant to the nurse, but one that, I

retrospectively note, is associated with accelerating patient discharge; “...*this was a much more formalised process to be audited...the forms went into the notes, and there they stayed. Nobody signed them, nobody actioned them and however many months on we are now, it’s not been revisited, a total waste of time....*” Liz continues with the narrative “...*I think the general impression from higher-up is that we don’t do enough to discharge patients quickly enough. They believe that we’re not pushing the discharge issues quickly, and I think it was a way and a tool to be used to push this process along and actually have some, sort of, formalisation and a protocol for the Trust, that they could present to the Assembly and say “This is what we’re doing”* (1, par 72-76).

When I enquired why it had not worked however a medical surface of resistance emerges; “*The Consultants didn’t take it on fully...They all made the right sounds...but when it came down to it, they didn’t actually push that forward. ...The other issue was that we didn’t really have the patients that were appropriate. You’ve got so many complex discharges on this ward and you haven’t really got many simple discharges, very, very few*” (1; par 88). It may be understandable why consultants do not engage, as this mechanistic tool, apart from being inappropriate for their complex and unpredictable context, potentially dissipates their position as authorities of delimitation for patient care.

Timely discharge has always been a facet of the nursing role, but possibly not one that would have been prior to efficacious treatment and progress, but it appears that care is now being judged and measured against a new form of specification; its inter-discursivity with efficiency discourse is not only evident, but ordained as all my respondents accounts are preoccupied with statements that assert the constant need to avoid delays. The interviews reveal that a whole team of managers are employed to attain this obligation, *bed managers* (3, par 17), *delayed transfers of care managers* (2, par 36), *intermediate care managers* (6) and *discharge liaison nurses* (6, par 286) are some of the roles referenced; roles that straddle the ward level and corporate level management.

The impact of scientific management on the clinical field however, takes a startling turn in my second interview. Mary had mentioned it earlier; “*getting*

*patients to their predicted destination*” (2; par 25) and uses the term “*predicted date of discharge*” (2, par 303). At first I see these as buzz words, perhaps new politically correct management euphemisms for ‘going home’ or to avoid the word ‘death’, but no there was a more subtle pointer to linearity in the word *predicted*; the narrative continues that on admission not only do they predict where a patient is eventually going, but on exactly what day they will go; a far cry from a medical prognosis.

Both the ward sister and the performance manager tell how the Trust has spent massive amounts of money on a computer program and training to ensure that discharge dates are not breached (1, par 30, 2, par 27 –36). The linearity of this modernist mode of surveillance is alarming me. I laugh uneasily at its absurdity. Mary explains that; “*when the patient arrives they are in the green area, if they went past their predicted date they went into a red area and if they went past this they went into the black area and this should then be transferred to the Chief Executive*” (2, par 34). Mary can see the amazed expression on my face, that the Chief Executive must be contacted, and gleefully continues; “*who is going to put it all right...never happens, never happens*” (2, par 34). She ponders about what the Chief Executive can truly do about the breach and suggests later, in a genuinely understanding moment that; “*he does not have a magic wand...he does not have the power to change anything and neither do we*” (2, par 60-62).

In support of Seddon (2005), Mary suggests how these linear production-line values significantly impact on her every day working practices and explains, in a tone of both amusement and despair, that this processes of discharge is unrepresentative of the patient’s journey. She explains if patients are clinically unwell; “*you can’t bring them back down into green and start the process again, you just cant do it, [the programme] doesn’t allow it, it sounds like something from Little Britain, doesn’t it, the computer says ‘no’*” and to emphasise this flaw explains that; “*half the ward is black...the Chief executive must look at every medical ward and see a sea of black*” (2, par 303).

Mary adds; *“we don’t need a computer to manage us, but that’s what its doing”* (2, par 373) and James turns up the volume with a remarkably similar critique. One might expect James to reveal the linear and mechanistic philosophy expected of a manager, but he is unexpectedly cynical; *“you must have come across this very famous name called Elijah Goldratt, and his famous Theory of Constraints, and the Trust is spending an obscene amount of money, as far as I am concerned, and they told us zilch, which we didn’t know... Now, the Theory of Constraints, as far as scientifically I can see, is a very linear system... looking at the factory work where people are standing on the assembly line assembling things and if one component doesn’t work, obviously it backlogs, so he implemented a similar system in healthcare and became more or less mega rich, and telling people actually what they already know in a different format”* (3, par 30).

As the stories about patient throughput gather voluminosly, imagine my delight at meeting Jo, an intermediate care manager whose role is directly involved in removing the ‘constraints’. Jo adds to the density, raising her voice to resist any perception of failure by the Trust, by clarifying how the lack of available beds in the community, the UA process, the WAG tool condemned earlier by Liz, and the fiscal fracture between social and health care is caught up in the linear system.

Meanwhile, as Mary’s cynicism abates towards despair, she adds a salient point that implies the futility of objective and rational management; *“I know they [the managers] look at the big picture, we [the nursing staff] just look at the small picture, but surely the small picture is the patient, so what is the point of looking at the big picture if you don’t identify that we are dealing with individuals”* (2, par 68). Not only is the computer programme, by its sheer existence re-ordering the perspective of care, as Hassey (2002) suggests, but my impression is that patients are being made to fit with a programmed linear process to enhance efficiency.

However, it is not only a discourse of scientific management that is revealed by these stories, as what is evident is a surveillance process that communicates

directly to the Chief Executive, even though (s)he is powerless to act and I ponder whether the surveyor is actually at the political level. Whether it is politicians or managers that survey, in reality matters not, it is the fact that some have the authority to survey and judge the performance of others, surveillance is a form of power that is, insidiously and rhizomatically, (Deleuze and Guattari, 1988) circulating through the wards reinforcing a reality that refocuses the mind on performance as throughput.

The nurses stories in particular replicate Hau's (2003) critique that nurses are more preoccupied with the day to day struggle to free up resources (2003:2), which Hau concludes, is a way *to make nurses tow the financial bottom line* (2003:2), but as Mary asserts frequently; *"its taking us away from patient care again...it doesn't sort out the problem...just gives us extra work"* (2; par 58). What these stories indicate is a loss of autonomy or 'empowerment' at the clinical level; the linear reporting and communication processes are passing responsibility back up the bureaucratic line to the Chief Executive and this ultimately can only stifle ownership and any local innovation.

### **The Discourse of Performance Management – *Bend It Like Beckham***

My exploration of the Board minutes reveals a subject that supersedes all others in its importance, the meeting of performance targets within the allotted budgetary constraints. However, my respondents, other than James, do not express any imperative for meeting targets and I sense that clinicians, in particular, may be protected from this raw quantitative discourse even though it symptomatically appears at ward level via concerns relating to discharge activity.

Patrick's contends that targets are *"a core part of the day job"* (4, par 211), but their mention changes the course and the tone of the interview and Patrick becomes uncomfortable, choosing his words carefully, not sure how to clarify events in a 'politically correct' manner, perhaps to a fellow clinician. Although concerned about meeting ever-increasing demand and *getting patients through the system* (4, par 277), Patrick states that targets are an *everyday conversation...that's what it's like at this level [management level]* (4, par 243)

and suggests that the consequence of the Trust not meeting certain targets might lead to a *dressing down* (4, par 251) in some Minister's office. Patrick believes that targets correlate with improving patient care; “[they] will help because patients won't be staying in, getting infections...Finances will not be overspent because people are in ITU for longer” (4, par 243). Patrick's statement however re-orders the privilege, as although he suggests the financial targets are of utmost importance to the organisation, he (re)defines health care in terms of clinical outcomes, where financial thrift is the knock on effect.

However, Patrick's reveals how targets distract clinical practice; “if you have a cancer patient to scan and an ortho patient to scan, you can't screen both, so one of them has to take priority, you're going to breach...you'd like to think its on clinical urgency, but sometimes, all things being equal, if you can't show clinical urgency you scan the one you want to meet the target...and that's clearly what clinicians don't like and I can sympathise with them...” (4, par 259-263). Although Patrick argues that the consultants are, at times, ‘their own worst enemy’ his comments demonstrate that doctor-manager relations are aggravated by the priorities of targets (Baker, 2000; Garvin, 2004; Plochg and Klazinga, 2005; Som, 2005). Patrick's self sympathises with their loss of authority, maybe sensing that the way government targets marginalize the clinical voice is morally wrong; it is the government that speaks with authority and Trust decisions mobilise this authority.

Although clinicians say little about performance targets James being directly responsible, makes up for this lack and not unexpectedly his stories focus on meeting the challenge (3; par 26, 656, 991). James explains that increased demand requires the hospital must open another ward but; “we open extra capacity at cost...it is even more expensive than a normal bed” (3, par 88), an opinion reinforced by the Board minutes (01-07). I glean the alternative is the need for medical patients to infiltrate beds in other specialities, meaning elective cases have to be cancelled, again a concern reiterated frequently in the Board minutes. A butterfly flaps its wings; medical outliers rebound on the performativity of other specialities, which according to the Board minutes have even stricter targets for referral to treatment times. I note a comment by Jane, on

the paradoxical situation that the Trust faces; *we've lost twelve beds at a time when we've got huge waiting lists*" (5, par 99). James statement that the Trust saving target last year was *"21 million and this year is 28-29 million"* (3, par 644) is a possible reason.

David and James, however, cite another causal factor clarifying how demographic changes distort the definition of acute care; *"We're not maintaining the four hour target ...the age profile of those admitted is far higher than it was* (8, par 48). As Jo suggests *"you can't make somebody better who couldn't walk before and that as basic as that"* (6, par 278). James pragmatically states how the nature of this 'elderly' clientele is such that they are very rarely medically fit for discharge; *"elderly people are not acute they are long term"*. He is not being rude or ageist, but logical and realist. It is a point he makes several times throughout the interview, but what James is defining is that medical wards focus on acute illness and this is short-term condition, he is drawing the boundary around an acute care discourse.

By telling this story I feel James is attempting to re-stabilise his self and the expectations placed upon him by management. James' argument is also reflected in Liam's account of continuing care where long-term care does not always fit in *separate boxes* (7, par 109). Jo also reveals the *greyness* surrounding the definitions of care against which the Trust is measured and care is funded; *"the Government have been deliberately vague about it all"* (6, par 174). From a Complexity perspective, the Government performance targets assume that care can be defined, differentiated and bounded in separate closed systems, but clinicians' stories voice the futility and the impact of this fragmented perspective.

The Medical Director suggests that targets focus on what the public want and that; *"the politicians vocalise this"* but quickly retracts this opinion suggesting that the public are not fully consulted about what they want; *"we need to be asking the public what they want of the NHS"* (8; par 303). James asserts that the Chief executive should be able to *"just stand up in front of the public and say, "We've failed, I'm sorry." We fail because of the sheer politics involved"*



(3; par 741). The frustration at the lack of Trust autonomy is obvious and James comments reflect how the masquerade of performance management continues to feed governmental rhetoric and generate political spin.

### **Summary**

If I had any doubts at the start of this research about the negative impact of managerialism on discursive practice then this section reassures me of my instinct. The statements of respondents demonstrate and sustain the leader-follow dichotomy and a polarised model of power (Knights and Willmott, 1999) where the relative positions of power between various agents in the system are mandated by their stories reinforcing the limits of their authority.

It is a polarity historically grounded in the secondary care organisation through a professional discourse and I ponder whether some agents have legitimised this expectation to an extent that they tolerate or even prefer its dominance, a phenomenon that cyclically reinforces elitism (Arendt, 1970; Grey 2005). This situation reflects *negotiated order* (Richman and Mercer, 2004) and reminds me of Baskin's (2007) comments that; "*children need their parents to exercise power in order to feel safe and to succeed...and children welcome it, even when they rebel*" (2007: 4), suggesting how health care staff legitimise the power of rational authority, when used appropriately, to progress and protect their livelihoods. It is certainly a thought that matches my own experiences, where compliance is unconsciously driven, in part, by the career structure (Savage, 1998) and the prospect of promotion (Knights and Willmott, 1999).

My findings also infer a loss of both clinical and managerial autonomy over their own activities, resulting in agent anxiety and frustration. At the management level the fear is not meeting performance management targets and at the clinical level frustration is wrought by the dominance of statements that attend to the efficiency rather than efficacy privilege. The incursion of scientific management at the clinical level, in the attempt to meet targets is startling, but although the linear task focus is distracting them from providing care in a patient focused way their resistance spontaneously allows them to self-organise in a

truly remarkable manner. Clinicians attempt to preserve the status quo by not allowing standardisation to stagnate the system.

Whereas the clinician self is clearly constituted by the performative discourse of managerialism, as the normative logic of their habitus evolves, my clinical level respondents are instinctively aware of the need to keep reflective and reflexive and their discursive practice rather than submit to the constraints of managerialism is co-evolving the clinical and managerial priorities. My concern is whether discursive practice can continue in this way or whether discursive closure will force them to subjugate their discursive hysteresis and submit to a discourse that forces equilibrium, but stifles innovative and safe practice.

### The Impact of Clinical Governance – *The Odd Couple*

Changing the discursive trajectory of governance, my analysis now explores the extent to which the discourse of clinical governance acts as a convergent ‘regime of truth’ bolstering the central tenets of managerialism from a clinical and professional direction.

My earlier exploration of the literature suggests that a political re-definition of health care, through a lens of failure, would persuade clinicians to validate the ideological truth claims of clinical governance (Hurst, 2003; Nicholls *et al*, 2000) and thus I am interested to explore whether my respondents’ statements do validate its rational, linear and universalist methodology (Loughlin, 2004).

### The Scientisation of a Caring Discourse- *The Graduate*

The nurses’ interviews make explicit that the discourse of caring is evolving as their stories form a critique around their newly found status as a graduate profession and how nurse training is now incorporating an increased level of academic intervention. Jo recalls that when she trained she was; “*included in the numbers and my third year as a student nurse I was in charge of the ward...and so you take things more in your stride, when you qualify there isn’t that big jump...you start to use your own common sense and your own initiative*” (6, par 50).

Jo is illustrating the loss of a highly experiential form of learning, an apprentice style of training where nurses learn through practice. Jo's comments mirror Smy's (2005) opinion in their denouncement of scientific transformation; "*we've done this drive and we want to be independent professionals, we want to be autonomous and actually that's not what I see myself being, as a nurse and I think its been to the detriment to nursing to pursue that.*" (6, par 62).

It is remiss of me not to probe who the *we* she refers to is, but I assume Jo means those who speak as authorities for nursing, their professional body; The Royal College of Nursing. I think the question arises is why this transformation and drive took place. Jo's comments conjure up thoughts that historically nursing has been subjugated as a profession, as the literature suggests, but there is no suggestion of a gendered causation (Bilton *et al*, 2002; Melia, 1987; Short Sharman and Speedy, 1993; Wood, 2000) only that nursing is now emancipating a new voice through academia and qualifications.

Mary's views are similarly mixed as explains how the expanding "*academic base*" is underpinning nursing as an autonomous and credible profession, a new canonical foundation that is emancipating the image of the 'doctor's handmaid' into nursing into a true profession. Academic intervention adds the credible scientific form of clinical knowledge needed to validate any profession; scientific knowledge spoken by academics, the new authorities of delimitation, speaking on behalf of those who practice.

What this evokes in my thinking is that the object of nursing care is taking a scientific trajectory, reflecting the literature that considers that caring, once thought of as naturalistic, intuitive and experiential (Falk- Raphael, 1996; Hau, 2003; Richman and Mercer, 2004; Stark, Stronach and Warne, 2002; Wright, 2004) is now embracing statements that aspire to both a mechanistic and rational evidence-based research model. This may explain why Mary, after celebrating their new found credibility, supports Hassey's (2002) conclusions that patients are becoming labelled as conditions and thus cementing in place a linear model of nursing practice; "*... we have gone back to task orientated care, we're not going back to individualised patient care which is what they wanted us to do.*"

(2, par 142) arguing; “...we’re not dealing with numbers, we’re dealing with individuals and individuals are very different...even if they have the same condition, they have too many variables...it’s not cut and dried” (2, par 68).

This scientific intrusion is supported by the Trust as the Board minutes ratify the *Fundamentals of Care* (2001) strategy, a political discourse that attempts to reduce caring into tangible and measurable tasks. This report makes recommendations on service re-design and workforce development, again suggesting the convergence of scientific management in the field of nursing through the standardisation and devolution of tasks, underpinned by academic intervention and an appeal to evidence-based nursing.

Mary argues that training is now overly formalised and revisits the importance of her ‘informal’ teaching role; “*the academic side is very important, but so is the practical side*” and continues that “*it’s not what you can do academically but what you can do as a person...*” (2, par 23) and by raising this point implies that ‘informal’ teaching is subjugated, maybe thought of by academia and managers as *savoir* (Foucault, 1980a) in relation to its academic counterpart, a misplaced thought as ward-based teaching would not wholly consist of experiential knowledge but would represent a crafting of *connaissance* with the practical *savoir*.

### **Standardising the Complex Patient – *Blade Runner***

The evolution of nursing practice towards a task focus aims to facilitate the systematisation of patient care with the aim of constructing predictable clinical outcomes (Sweeney and Cassidy, 2002) and this this allows the discourses of scientific management to enter the discipline from a clinical direction. The task and linear focus is recognised in Liam’s concern about the differentiation between acute and continuous care and in James’ and Liz’s description of UA process but Jo and Mary give more dramatic accounts of how the task led focus is impacting on the role of the nurse.

The Board minutes mention of the *Patient Acuity Tool Project*, the *Care Programme Approach Policy*, the *Policy for Pressure Ulcer Risk Assessment*

(02-07) the Safer Patient Initiative (03-07; 04-07) and Daily Goal Sheets for Patients (04-07) resonate with Mary accounts of the need to score patients for nutrition, pressure sores and incontinence (2, par 146) and does suggest that the complexity of nursing is being reduced into separate tasks, with specialists assigned. Zerubavel (1979) recognises this phenomenon in American hospitals; the patient is becoming a unit of time, subjected to constant and mechanistic surveillance.

Again I must re-consider my impulsive thoughts, as this is not necessarily an unjustified trajectory and may be spontaneous adaptation in the face of advances in medical knowledge, technology and patient safety, but of concern is that the discourse is beginning to standardise not only the treatment but also the patient. What this means for clinical care is that the freedom to practice individualised patient care is potentially constrained, removing the flexible and intuitive elements of care that complex patients need.

As a consequence, both Mary and Jo's (6: par 148) denouncement of the specialist fragmentation of the role supports the view that managerialism is distorting individualistic care and removing the challenge from nursing (Corbin, 2008; Hehir *et al*, 2006; Kitson, 1999; Madge, 2006; Salvage, 2006; Watson, 2006). I leave Mary to express her concerns for the way in which patient care has been broken down into "*individualised tasks*" that as Fletcher (1999) would say 'disappears' the individual patient.

*"We do three years training, we come out of training as qualified nurses...now over the years we've had nutrition nurse specialists, continence care nurse specialists, diabetic nurse specialists, wound nurses, those are just four off the top of my head, so now I look at a patient who has a pressure sore, is malnourished and incontinent, so do I walk away from that bed and not give any care and spend half an hour trying to get the nutrition nurse to look at his needs, the continence nurse specialist to tell me how to manage his incontinence and the wound nurse to tell me what to put on their dressing? So, I've got three calls to make to three different people, when all I have to say is that 'that chaps incontinent, he probably needs a catheter and regular turning, on his wound I*

*will put this sort of dressing and encourage him to have some drinks as well as eat a little bit more, but Nooo (stressed) I've got to ring three specialists who come and expect me to have done a nutritional risk score, a wound risk scoring and expect me to have done an incontinence chart ...all before they even look at my patient, when all I have to do is make the decision 'this is how I am going to nurse my patient because I have spent three years in training and extra study days to tell me how to do this!'" (2, par 146).*

Another dramatic impact of the task-focus is the standardisation of work and, in true Taylorist spirit, this transition lends itself to a shift towards a discourse of scientific management and the delegation of many medical and nursing roles; the Marxist 'proletarianisation' that erodes clinical autonomy (Child, 1982; Garside, 2004). Mary uses the term *de-skilling* (2, par 259) and is an interesting choice over 'delegation' and I pause a moment to consider what it signifies.

De-skilling is not an uncommon term in the NHS, but is significant as it presumes a loss of skill, whilst the converse is equally true; it depends on your standpoint. Thought of as an outcome of lean management (Grey, 2005), rhetorically it might be dubbed delegating, devolving or even empowering, but because of my personal experiences I too tend to cling to the negativity of the de-skilling image as I have witnessed a similar change first hand.

More significantly, what I see happening is the loss of professional knowledge. The skill is transferred, but what is not transferred is the knowledge or the enunciative power that accompanies such knowledge. Nor does a skill arrive unarmed, but with a bundle of procedure based rules and algorithms. The power does not rest anymore with those performing the activity, but shifts to those who govern the procedures and may be considered a way of removing power from the once powerful discourses of medical and nursing knowledge and replacing it with a regulatory mechanism of power and processes of surveillance.

Hence, nothing could surprise me more, although retrospectively was inevitable, is the timely publication by National Institute for Clinical Excellence (NICE) of *Clinical Guideline 50: Acutely ill patients in hospital: Recognition and response*

*to acute illness in adults in hospital* (NICE July 2007) The detail of the guideline is irrelevant, what is important to recognise is the need for such a guideline. I can only surmise that it is a consequence of transferring or delegating nursing tasks and feel exasperated that it seems to be another stick with which to regulate and control the workforce in the face of 'lean management'.

### **Discourses of Surveillance as Risk Management – *Panic Room***

With regard to the sentiments expressed vehemently in the previous paragraph, it is understandable that delegation and the loss of tacit knowledge necessitate the introduction of risk management processes. Prescriptive interventions, the loss of autonomy and the loss of knowledge constrain a system from self-organising and adapting locally according to patient's needs. When it fails, as Blomquist (2000) suggests, mechanistic thinking assumes failure is due to some missing link in the linear causal chain of rationally planned events or that implementation has been thwarted with incompetence, lack of control or co-ordination. However, I find it unusual that none of my respondents criticise the quality of clinical care. James' actually comments that "*if you look at quality, the Trust is performing now*" (3, par 538), an opinion that seemingly contrasts with the thrust of government spin.

Mary offers an example that suggests the intrusion of *governmentality*, through clinical governance, technologies of government ordering practice in an identifiable manner (O'Malley, 1996); "*We risk assess every patient that comes through that door, whether they are fit and healthy walking in, they still have a risk assessment done, because that's what we're told...so we are doing this three page document for every patient...*" (2, par 112). Mary contends that those who are with the patients 24/7 continually weigh up these risks and spontaneously act to try and prevent a fall; they don't need a form.

Mary also emphasises the increasing burden of documentary evidence (2, par 184) recognised by Hardveldt (2006) and her written reflection (2a) highlights a discourse of surveillance fashioned through increasing documentation; a convergent grid of specification where the referential knowledge of these fields

are inter-twined to form a cohesive and documented body of *connaissance*. Mary recalls the professional code of conduct.

*“Good record keeping helps to protect the welfare of patients and clients by promoting, high standards of clinical care, continuity of care, better communication and dissemination of information between members of the inter-professional health care team, an accurate account of treatment and care planning and delivery, the ability to detect problems, such as changes in the patient’s or client’s condition, at an early stage”* (Nursing and Midwifery Council, 2004).

I make no judgment on the principled virtue of this statement as no doubt documentation is an essential element of care, but what is of significance is that this statement emerges from the regulatory body for the nursing profession, the nurses’ authority of delimitation is speaking in a language of surveillance and cements this in place by a weighty statement that cements documentation as the root of competence.

*“The quality of your record keeping is also a reflection of the standard of your professional practice. Good record keeping is the mark of the skilled and safe practitioner, whilst careless or incomplete record keeping often highlights wider problems with the individuals practice”* (Nursing and Midwifery Council, 2004)

Moving to another risk minimisation intervention recognised in the Board minutes to minimise infection rates, SPI, Jane recounts, in a military tone, how, *“A new project will come along and the whole trust will run;”* Right this is what we’re doing” so we work blinking hard at it, right when we’re getting to the end of it, when we just begin to start, we’re off on another thing...we seem to hang our hat on the next thing that comes along; *“This is going to make it all right”* We ride on it like there’s no tomorrow, then we run out of steam because we’ve worked do hard on it but we haven’t actually seen it come to fruition, and say *“was it successful or wasn’t it?”* because we’re all somewhere else” (5, par 112).



I recognise an intervention that again aims to simplify the complex through linear causation. I enquire after a remarkably similar sounding project I recollect from my own practice. Jane seems delighted; *“seeing as you’ve raised that, two or three years ago that came in and it was the big thing, everybody had to be trained in [process] everybody was released off the wards, the world and his wife. I’d like to see when it is put into practice”* (5, par 544).

However, more importantly Jane exclaims angrily; *“we have to do it, we’re driven, if you need training up then we train you, the fact that you will never use it, tough! We’re driven by the things that come along, tick the box, ten people here, ten people there, done it!”* (5, par 552). Jane alludes that it is the political levels that are in the driving seat and her aversion to the way ‘the tail wags the dog’ is evident.

### **Processes of Accountability – *The Producers***

The risk assessment process goes hand in hand with clinical audit, a tool of clinical accountability. Mary states that, *“audit is an investigation isn’t it, everything is investigated”* and adds *“somebody is sat there collating the information, what they actually do with the collated information nobody knows because nothing ever comes back down to us”* (2, par 64).

Mary is frustrated at the number of interventions imposed on the ward *“from the Chief Executive, the Hospital Board, or from the Welsh Assembly Government,”* (2; par 243) and explains that, *“this is where audit fails, we can audit until we are blue in the face, but unless we have feedback what’s the point...we just gather information for other people which is a very frustrating aspect of the day to day work...The idea of audit is to eventually change practice, make recommendations and re-audit, it’s a cycle isn’t it?”* (2, par 140-145).

However, discourses of surveillance and accountability are not only visible at ward level. The clinical governance manager, Jane explains how processes have changed to logistically accommodate the increase in ‘incidents’. She remarks how all *“proper complaints should come in through the Chief Executive...then they come to me ... at the end of the year we are able to see how many inquiries and compliments we have and in a particular area...we can produce good*

*quality data which shows not only the work we do, but how we manage these in the same way as a complaint logged formally” (5, par 207).*

Initially my disquiet at this description lies in how what used to be a rather straightforward process has been formalised, systematicised and computerised to accommodate an inventory of every piece of correspondence that crosses her desk, especially poignant as she gives no hint that correspondence received at ward level (2, par 155) is treated in the same manner. Jane reveals a surveillance system, that mimics Foucault’s (1977) notion of *the gaze* or hierarchical observation and it is notable that she states that Chief Executive peruses all complaints before they reach her desk. Is the Chief Executive, in true Foucauldian spirit, surveying the surveyors through a linear form of ‘sovereign power’ dove-tailed into a discourse of mechanistic norms?

Jane continues with an example of an incident, but already the linear, mechanistic and determinist process appears messy and I sense that she is deliberately exaggerating the distended procedure,

*“... code it up, is it a complaint, a concern or is it an enquiry; so we would allocate it to those codes, they then go to the clinical co-ordinators, they log and code it on to [the software programme], write to management, ask for consent to come back, when consent is required. Then it goes to the directorate manager who investigates that complaint, ...so they would feed back the response to the co-ordinator, who would check it, make sure those were the issues raised, were those the questions raised, if not send it back, sometimes it is reasonably ‘fit for purpose’ reasonably well written, so they [the co-ordinators] can be writing the whole response, top and tailing it into the right format, the right structure, get the appropriate person to sign it off at the end, that is the Chief Executive, then it goes to head of Nursing, who checks it for accuracy in respect of the response and makes sure it is quality checked, explained all the jargon, putting it in lay man’s terms and then the general manager signs it off, its almost finished; and then it comes back to be sent out and logged on the system...and we’ve got to do this within twenty days.” (5, par 214).*

I'm exhausted just listening to such precise instruments of surveillance, but in bureaucratic organisations it is recognized that the mechanism of 'gaze' operates at various points throughout the structure (Hopper and MacIntosh, 1998) and as Dandeker (1990) would suggest that this not unusual to establish and reinforce the power relationship between two conflicting parties. Is it a tactic by which the patient complaining is also being controlled?

As Jane confirms the fact that information on the complaints procedure is disseminated as part of the core pre-admission document it suggests that patients are now made aware that they cannot just complain to the doctor or the ward sister anymore, but must involve the Chief Executive setting off an algorithmic flow of documentation, monitoring and evaluation. Jane, although sounding uncomfortable at this extravagant process argues that that informality will only "*come back and bite you on the bum*", as she suggests, "*who's to say that conversation ever took place*" (5, par 237) supporting Granovetter's (1994) concerns that surveillance acts as a functional substitute for relations of trust.

Trust is being replaced by a mechanism of power that as Foucault (1977) would suggest appears outwardly logical and innocent and both patients and staff are not necessarily consciously aware that their actions are being controlled through this apparatus of control that promotes docility through monitoring and documentation. The necessity for excessive recording is a mechanism that feeds on the fear of being criticised, the need for accountability (Foucault, 1977) but I might ask, criticised by whom, the public or the government?

What I am envisaging in this CES is a distinct loss of trust cascading through the organisation, constraining the transparency and connectivity that trust needs but Jane substantiates that the Trust is merely implementing Welsh Assembly guidance for complaints. If this internal surveillance mechanism of self-management is difficult to digest Jane, reminds me that the Assembly reviews all the data annually, it is they who have generated a hierarchy of surveillance, a capillary like form of power that is infiltrating all scales of the health care system countering the tripartite relations of trust between the public, the Trust and the government.

This type of modernist accountability is recognised as a technology of control through monitoring and regulation (Loughlin, 2004) and thus reinforcing a need for managers (Connelly, 2004). This latter point is confirmed by Jane's statement; "*we are monitored to such a degree, we're having people in to do the monitoring of the monitors*" (5, par 512). Jane's anxiety is voiced further with regard to the benchmarking of complaints which she argues that; "*it's not a balanced playing field*" (5, par 249). Due to an inconsistency in the interpretation of Assembly guidelines the improvement that benchmarking is expected to generate (Northcott and Llewellyn, 2005; Waite and Nolte, 2005) has deteriorated into a semantic debate over terminology.

### **Summary**

My interviews portray how clinical governance is acting as a powerful and convergent regime of truth that bolsters the rational and scientific framework that underpins the massification of health care from a clinical and professional direction. As the literature suggests (Davies, Mannion and Marshall, 2001), defining the object of health care through a lens of clinical failure justifies an ideological approach to hasten a systematic and scientific approach to clinical activity where the complexities of patients must be reduced to fit a collective and standardised model of care.

It is clear that the nurses, in particular are uncomfortable with this collective notion of 'ordered caring' (Falk-Raphael, 1996) and their frustrations raise concern that a scientific discourse is engendering a task focus that results in fragmented care and constrains their inability to remain flexible and to give holistic and individual care. In addition, academic colleagues are acting as authorities of delimitation by seemingly marginalizing experiential knowledge, as *savoir*, and ordinating evidence-based *connaissance*.

As I surmised in chapter four, these convergent regimes of truth are driving the system towards equilibrium. The loss of emergent change is substituted by the processes of risk management and audit, processes of surveillance and accountability that appear tolerated rather than legitimised, suggesting that

nurses feel powerless in the face of a discourse that is now being supported from professional, clinical, public and academic surfaces of emergence.

### Relating the Findings to the Research Themes - *The Full Monty*

My theoretical ontology of the secondary care organisation is premised on the existence of a discursively constituted CES who, regardless of dominant claims to the truth would continue to self-organise and (co)evolve. This section returns to review the findings in relations to the major themes of this thesis and discusses its potential impact on the context as a CES.

As each agent relates their everyday life they offer a unique glimpse of their self and the way their self is being reconstituted, influencing their discursive practice. The manner by which this practice is ordered, however, is of significant interest to my thesis, especially if their (in)action dissipates the differential of power needed to sustain self-organisation and the spontaneous transformation to new order. To sustain a reflective, reflexive and safe working environment, agents in a CES must have reciprocity, where agents are able to negotiate new patterns of legitimised order rather than have order imposed upon them.

### **Revealing the Extent of Discursive Closure – *Equilibrium***

At the outset this research sought to reveal if mechanisms of power, exercised through managerialism, attempt to maintain discursive closure in favour of a particular reality of secondary care. Looking back at the analysis of the minutes of the Trust Board meetings, the impact of a political discourse, that defines the secondary care context as inefficient, wasteful and failing is clearly closing and dominating discussions (re)validating its ‘political reality’.

It is perhaps not surprising, therefore, that my findings depict statements of managerialism cascading through all scales of my context, privileging the statements of performativity. I recognise a web of converging discourses that emanate from several diverse and often unexpected surfaces of emergence, managerial, political, professional, academic and public, entrenching discourses of rational strategic management, science, surveillance and conformance and

placing managers in a functional and dichotomous position between the political and operational level.

Participant accounts unveil narratives that indicate the dominance of political discourse, both at the strategic level and at the operational level. Stories relate how commissioners marginalize clinical discourse with regard to decisions about which services should be prioritised or ‘rationed’ (7, par 56-67; 8, par 56-64; 303) and discursive closure and dominance is apparent at the operational level where stories continually refer to patient throughput and the notion of ‘delay’. Throughout the findings I recognise the loss of autonomy that I remember from my own experiences.

The dominant power relationship is mandated through specific protocols, such as Unified Assessment (1, par 128; 3, par 60-68; 7, par 204) and Protocol Led Discharge (1, par 72), hierarchical structures and discourses of surveillance (2, par 64; 5, par 112) and performance management (3, par 605). The constant themes of ‘delay’ and ‘risk’ invite clinicians to legitimise these priorities within their own actions and in doing so the closure intensifies. Tolerance and apathy, even though accompanied by anxiety, frustration and resistance, merely act to embed performativity in the normative logic of the clinical context and the habitus of each agent.

### **The Discursive (Re)constitution of Self – *Face Off***

The second theme of this study sought to explore how the reality presented by dominant discourse impacts on an agent's self and the findings reveal that dominant statements of performativity and surveillance, wrought through discursive closure, are beginning to impact on the constitution of self and an agent's consequent practice.

Political rhetoric is a persuasive tool in the way it can order particular definitions of health care, as failing and inefficient, re-constitute the self and generate discursive practice in a way that reinforces this particular image of reality. I consider that, like me, my respondents discursive practice truly legitimises the performative aspects of service delivery and do attempt to balance these competing demands from their own subjective perspectives, but I

consider that convergent discourses of governance attempt to impose new values rather than allowing agents to transform these naturally and in some cases this transition is clearly discordant with the inner self.

The legitimisation of clinical governance and performativity is also influenced by the professional authorities of delimitation, such as the BMA and the RCN, who offer a distinct credibility, supporting a dispositive exercise of power, by backing changes to regulation, the delegation of workload and the universalisation of service delivery. Clinicians, however, do sense and voice their concerns at the subjugation of experiential knowledge, individualism and relational behaviour that managerialism disqualifies as a supposedly 'irrational' discourse, inadequate for the task at hand, by, as Foucault (1980a) suggests, disguising it within a functionalist and systematising discourse.

There are clinicians who have perhaps adapted their self more than others. Both Patrick and David, superficially at least, legitimise the logic of performativity, possibly due to their roles, where the clinical and performativity discourses interact, but I sense both have a greater degree of control, where their autonomy can emancipate the clinical level voice, by motivating clinicians and consultants to be involved in managing the system. Jane's self is also transforming, accepting the logic of a clear audit trail of documentation in the face of potential litigation, but her self refuses to de-humanise the patient and like Mary, her discursive practice attempts to accommodate both. With regard to Liam and James, their more recent introduction to health care experiences may have legitimised the performative aspects to a greater degree by having not experienced the 'freedom' of the pre-NPM environment.

### **The Resilience of Self – *The Empire Strikes Back***

The final theme of my research aims to disclose the existence of competing, dominant and marginalized discourses at the micro-level and in what ways these are legitimised, tolerated or resisted by agents and what this means for discursive practice. The previous section highlights that, at all scales of the system, the dominant statements of governance are reconstituting the self, but there is no complete acceptance of a politically ordained reality.

What is evident in many accounts, especially those of the clinicians, is the degree to which, once constituted historically, the self is notoriously difficult to shift. As agents critique their every day experiences, voices raise resistance and mobilise an alternative body of knowledge, as stories depict the existence of manipulation and gaming as a means to revive and exercise power to counter the dominant position.

Of interest is how both managers and clinicians employ this technique, by seeking support from significant authorities of delimitation, as a means to bolster a particular body of knowledge to champion their objectives although their emergent 'solutions' do seem to rest within bounded norms (McMillan, 2004; Mitleton-Kelly, 2003, Prigogine, 1997; Stacey, 2003). At the clinical level, I hear Mary asking a consultant to support her opinion regarding a patient discharge. Whilst the consultant is not keen to disrupt the discharge of a patient, Mary, thinking of both the patient and her colleagues, uses the relational capacity of the shadow system and the power of medical authority to support her stance.

*“ We had a patient the other day that they [the consultants] wanted to send home... but the dressings she needed would probably put strain on the district nurses and I felt that this lady probably wasn't ready to go home because I felt her dressings needed to be more manageable... so I spoke to the consultant and said can I put this across from a nurses point of view and he said okay...so between myself and the consultant we negotiated what the plan was going to be...he knew I was looking at the patient's best interests” (2; par 297).*

Mary's story demonstrates the power effects achieved by combining diverse surfaces of emergence to emancipate a clinical focus using the power of connectivity and interdependent relations, even social capital. What is significant is that the power generated by this resistive action, orchestrated through combining the power/knowledge from two fields, relocates the socio-centric focus and the clinical outcome in the object. It is these dimensions that are being displaced from the political and managerial definition of health care



and replicates Hau's (2003) research that argues that the model of care is being dominated by managerial objectives that stress the fast turnover of patients rather than being aligned with clinical ideals or patient welfare.

Baskin's (2005) research, with nurses, supports the profound effect of hysteresis on transformative change. Baskin (2005) recognises how nurses with a lengthy experience of secondary care, like Mary, consciously resist the way in which increasing demands are preventing her from giving a level of care that she had always provided, whereas less experienced agents were, like Liam, more open to change, not perceiving the same constraints. Mary's exchange is particularly potent in this respect and I wonder if this degree of resistance would be recognised in other agents involved in clinical service delivery.

Whether Mary consciously recognises her discursive practice in strategic terms or was naively focusing on the social and economic needs is debatable. I sensed that Mary had the wisdom to recognise the power effects of this decision although not in such raw terms. Another story, previously exposed, presents a similar clinical dilemma where the consultant attempts to manipulate the nursing sister, to allow him to accommodate a patient's treatment (2, par 68). Although the nurse refuses the request a suitable and bounded outcome for all was eventually reached, indicating how autonomous agents, inter-relational working and shadow systems can enable self-organisation in a way that accommodates inter-discursive privileges.

From a management perspective, James also explains how he manipulates the clinical power of consultants to achieve his performance objectives. One story describes how James begs a consultant for an early assessment of a patient, not, that I can detect, for any moral or clinical reason, but because it will allow a bed to be released earlier; *"we need your help...I don't care when you come, if you come today, I'll be grateful."* Anyway, she came. So I've sorted that out. *If we didn't, that's another three days lost*" (3; par 284).

A second story recounts desperation as James negotiates with a consultant to discharge a 'difficult' patient; *"I got involved because they [bed management]*

said, “[James], what are we going to do?” I said, “Okay, well, is he medically fit?” “Yes.” So I asked one of the guys [doctors] ... who is a very good friend of mine. You see, network it’s very important... now I ask him to go and review him and put it that, “You put him medically fit and I’ll discharge him” (3; par 372).

Mary and Jo present as historically constituted docile bodies, although the term ‘docile’ perhaps does not convey an accurate image of either as neither are passive, but their selves seem to cling, in Mary’s case almost desperately at times, to the traditional discursive unity of nursing. In both interviews whilst they relate the logic of academic intervention, possibly persuaded by professional authorities of delimitation, they remonstrate how this technical and functional approach is distracting the ‘standards of care’ that their selves have legitimised through their career.

Mary’s reflection certainly supports how the *self can be moved mechanically through discourse by the workings of power* (Kendall and Wickham, 1999: 54) reconstituting the self by her own actions that tolerate processes of surveillance and thus modifying the normative logic of her habitus. When such action poses a radical disjuncture with her hexis, rather than resist overtly, Mary, as Foucault (1980a) suggests, strategically retreats and reorganises her actions, covertly gaining support from others whom she perceives as sharing her truth claims.

Throughout my interaction with all my respondents I sense they subjectively discern a shift in the relations of power and the loss of autonomy to judge what is necessary for their context. Procedures that standardise remove choice and I deem that this is currently more oppressive at the clinical levels than at the managerial levels who possibly have a greater degree of manoeuvrability. Thus, at the clinical levels, discursive practice is adapting to accommodate such principles because they feel at times powerless to resist; conformance may reduce anxiety, but stories indicate the frustration and the low morale recognised in the literature (Hehir et al, 2006; Salvage, 2006; Watson, 2006).

### **The Discursive Impact on the Context as a CES – *Snakes on a Plane***

The interviews suggest that in some areas of practice, the dominant discourses of governance, acting as ‘regimes of truth’, are dissipating agency and thus the tension required to co-evolve discourse in a way that naturally re-legitimises norms and preventing discursive practice evolving in a way that can accommodate potentially conflicting values in a seamless manner. Although consultants seem less affected, the enunciative function of clinicians is being marginalized, subjugating the power of clinical and professional knowledge by reduced participation, a loss of control over clinical activity and professional regulation and through the loss of the social space to speak.

My major concern is whether self-organisation and flexible working practices can be sustained if this loss of power ensues and as the discursive statements of control and surveillance gather dominance, potentially exercising dispotitif power through a heterogeneous mix of discourses that emanate from seemingly every direction, political, managerial, public, academic, legal, professional and clinical. Stories do indicate that self-organisation is continuing in response to perturbation, however, the power/knowledge dynamic is being employed in an essentially negative manner, to resist dominant discourse rather allowing discursive practice to co-evolve in a productive manner.

Regardless of my above claims, I cannot ignore Patrick whose self has transformed managerial and clinical values and priorities in a way that removes their discursive binds. Patrick’s values are thus neither clinical nor managerial; Patrick suggests they are organisational, but they remain subjective and belong to his self only, but his discursive practice does progress a new vision of health care within the areas in which he operates. Whether this is because Patrick has a clinical history is not clear, even though I reflect on my self in a similar position, but what is apparent is that by removing the boundaries between discourses, Patrick’s discursive practice enables agents at the front-line to negotiate new working practices using the opportunities of new technologies rather than imposing change.

Although this process is orchestrated formally it demonstrates how, by removing the command and control philosophy, agents naturally negotiate and transform the fractal rules of the field to accommodate the modernist privilege. All agents have a greater opportunity to emancipate their bodies of referential knowledge and transform their own practice through negotiation. This latter philosophy sounds vaguely Habermasian and I do not disagree with Habermas's ideals, but stress that this process will never yield shared values, the compromise attained is partial and temporal, existing in an edge of chaos position on the modernist-anti-modernist continuum.

So, as Dreyfus and Rabinow (1986) suggest, Foucault's ontological portrayal of the social system does challenge the notion of the passive victim, portrayed by structuralism, and places complex human systems in a system where all agents do act in a manner that is conscious and volitional. Even though the techniques involved are somewhat negative this type of agency is crucial for a CES and supports the relativist vision that dominant or subjugated discourses do not exist, *per se*, but act as competing power interests and engender an adaptive tension that stimulates the differential of power, required for self-organisation (Prigogine, 1997, Taylor, 2001).

### **The Discursive Boundaries to Co-evolution - *Braveheart***

What is also apparent is that my findings reveal that the acute sector of the secondary care context is interdependently and reciprocally interacting with a larger social, political and economic eco-system (Mitleton-Kelly, 2003a; Kauffmann, 1995) on a day-to-day basis, but indicates that managerialism is attempting to close the system to eradicate the 'noise'. This closure is an attempt to achieve the planned activity imposed by commissioning bodies and to meet the key performance targets set by the Welsh government, by ensuring predictable outcomes. However, in a CES this philosophical approach is futile, as my finding demonstrate that the boundaries between systems are not impermeable as agent's continually re-open any artificial boundaries through stories that reveal interdependent practices.

Nevertheless, from a Complexity perspective, the freedom to co-evolve is being constrained by the fiscal arrangements between the health and social care, where bounded political definitions of acute, social and continuing care create difference and confine what should be an open system. The UA process, rather than progressing the discharge process, is further constraining co-evolution, erecting a barrier through its ability to validate or invalidate knowledge and sit in judgement of patients needs; delays ripple non-linearly through the whole system, manifesting in trolley waits, delayed discharges, admission avoidance and these 'diminishing returns' stimulate the political need for performance targets.

It is the understandable response of a 'business' endowed with finite capital to close the system, attempting to create system stability and closure by avoiding admissions. As Davenport and Leitch (2005) argue the need for public sector organisations to compete for resources reduces any chances of collaboration and transparency, but attempts to close the secondary care system is pointless, especially in its relation with primary care discourse and the necessity to refer. However closure is a natural survival response when the Trust is seemingly operating beyond the edge of chaos, unable to self-organise in a positive manner due to a loss of autonomy.

Co-evolution is not stopped, but it is certainly being hampered and generating the need for posts, such as Jo's, which reclaim a position of negotiation, collaboration and engendering emergent practice to fit the constraints in which they find themselves placed. Jo's practice in some ways epitomises the multiple micro-strategic approach to practice that Mitleton-Kelly (2003a) advocates for success.

### Conclusion to the Chapter - *Flight of the Phoenix*

This chapter presents a polyphonic picture of the secondary care context where each agent conveys a unique perspective of their health care environment and the eco-system in which they are embedded and with whom they attempt to interact. The findings reveal an ontological perspective of the organisation as

highly interdependent and interactive and emphasises the messiness and variability of everyday practice.

Although each subjective standpoint is diverse, patterning is recognised as my respondents relate of a series of events surrounding particular themes. The two most prominent themes are statements that repetitively voice concerns for standards of patient care, as individualised care, and the way in which the statements of performativity and surveillance feed this unease.

I consider that my findings reveal that the 'object' of secondary health care is being re-defined around a performative privilege without any concomitant allowance for discourses of efficacy. Even though each agent expresses a variable and unique perspective, it is clear how selves are constituted inter-discursively and they voice resistance through their stories, struggling to emancipate alternative perspectives of patient care, clinical efficacy and the emotional reality of every day practice.

Acting as 'regimes of truth', the dominant discourses of governance surge through all scales of the system, perturbing the fractal 'rules' of the field and embedding processes of performance management, staff appraisal and audit, processes that aim to engender stability through homogeneity and conformance and dictate the new normative logic around which the field is expected to self-organise. It is a perspective that matches and justifies my intuitive concerns regarding the way in which the dominant statements of managerialism and performativity infuse the selves of agents as they circulate and interact throughout the micro-level signifying a privileged perspective of health care reality as inefficient and wasteful; the *managerial meta-myth* (Adams and Ingersoll, 1990: 285). It is a 'meta-myth' clearly reinforced by the Trust Board minutes; the need to meet key performance and cost reduction targets prescribed by government policy and it is these concerns that formulate the dominant statements of the secondary care organisation and attempt to drive a set of discourses to achieve these goals by generating a state of ordered equilibrium through homogeneity and conformance.

As a consequence the scenario portrayed is not one of empowerment and trust, but one of anxiety and frustration, which can only have a deleterious effect on connectivity, interdependency and transparency, the fundamental characteristics for self-organisation and emergence (McMillan, 2004; Mitleton-Kelly, 2003a; Nicolis and Prigogine, 1989). Whether the performative privilege is truly legitimised in the manager's self is not conclusive as it appears that the views of managers, like clinicians, are marginalized and likewise subjected to a rational, scientific discourse that treats managers as merely controllable and functional entities.

The impact of linear and mechanistic processes on patient care ought to raise concerns, both politically and managerially, as it is clear how, together with the concomitant discourses of regulation and surveillance engendered by clinical governance, they risk stifling clinical flexibility, innovation and safety. The way in which dominant statements of managerialism skew discursive practice towards performative issues, dissipates the innate diverse subjectivity essential for adaptive transformation; true co-evolution is thwarted and agents self-organise through resistive mechanisms that manifest as preserving activities, manipulation and game playing. Any productive aspects to micro-level power is dissipated as attempts are made to unify the direction of power forcing agents to react in an autopoietic (Maturana and Varela, 1980) manner, protecting their environment from strange attractors rather than co-evolving with them.

However, I must acknowledge that the convergent discourses of governance that directly impact on secondary care is merely one component in this detrimental transformation. My findings wholly elaborate on the complexity of the health care eco-system, the futility of boundaries and the way in which a myriad of complimentary discourses interact from several diverse and possibly unexpected surfaces of emergence. This raises my apprehension with regard to the ability of secondary care to co-evolve in two dimensions.

Firstly, that political discourse engenders difference within the eco-system, removing the capacity to naturally co-evolve because of specific definitions of care, delineated budgets and contradictory policies. Secondly, is that way in

which the modernist knowledge, that validates each discourse, appears to merge on a common grid of specification, potentially creating a dispotitif exercise of power, which, in itself, removes co-evolution through the marginalisation of alternative claims to the truth and I wonder if my context is slowly becoming powerless to act in any alternative direction.

To finalise this chapter I admit that I am both amazed, but reassured that the system is able to self-organise and co-evolve. The docile bodies, especially those of clinicians, may be transforming, but the struggle to adapt does continue. Perhaps the maturity, experience and naturally interactive characteristics of agents innately recognise the importance of maintaining interdependent relations and this allows our CES to retain the tension, the differentials of power, enabling the system to operate at a far from equilibrium position. I recognise retreat but not surrender. Although micro-level power is not being employed in a productive manner they continue to, as Kauffmann (1995) contends agents jockey for position in a co-evolutionary dance; a phoenix from the ashes.



**Chapter 7**  
**The End of a Beginning**  
*- The Morning After*

## **Introducing the Final Chapter**

*“I do not really wish to conclude and sum up, rounding off the argument so as to dump it in a nutshell on the reader...I have meant to ask the questions, break the frame...the point is not a set of answers but making possible a different practice” (Kappeler, 1986: 212).*

As I author the final chapter to my thesis almost four years has passed since I began my epic voyage, but I this does not mark an end to my scholarly and personal journey. This chapter marks only a hiatus in my travels through the health care landscape allowing me to retrospectively reflect on my glimpses of local ‘cultures’ and ‘customs’ of those that I have met along the way.

Having situated this research in a post-structural frame of reference it is paradoxical to compile a coherent conclusion from such diversity and a major question I must ask myself is how I can judge its success. This chapter now revisits the focus of this study and the themes around which it is organised, reviews the extent to which these have been addressed and discusses the potential implications for secondary care practice. The major intention of this critical inquiry is, as the focus describes; *“to inform and destabilise the dominant thinking of NHS management practice”* (page 2) and to *“to communicate an alternative orientation of the organisation, exposing the assumptions on which modernist modes of governance are founded and to reveal how managerialism seeks not only to physically control but applies oppressive mechanisms of power that drive into the very ‘soul’ of professional values”* (page 8).

I consider my findings, although context specific, have gathered ample data to reveal how the socio-political aspects of managerialism influence agent action providing a substrate with which to inform a scholarly debate that critically challenges the dominant norms and assumptions of contemporary secondary care management discourse. As my methodological approach argues, my critique does not seek generalisations or specific explanations, but allows me to explore the discursive constitution of my respondents, in relations to the major

themes of this inquiry and the way in which my respondents interact with the statements of managerialism.

In terms of its achievement, this thesis does contribute to two distinct bodies of intellectual knowledge. Firstly, my critique raises several poignant thoughts that support and evolve the body of knowledge about NHS management practice using a new ontological perspective of the secondary care system as a polyphonic and complex evolving system; a perspective that embraces agency, diversity and a new perspective ‘human order’ as an emergent and co-evolved phenomenon. Secondly, at a theoretical level, this thesis advances the epistemological understanding of self, agency and order within a Complex Evolving System by integrating the work of Bourdieu (1991; 1977) and Foucault (1980; 1972) and this conjoining of knowledge consequently validates my use of a reflexive methodological approach to studying complex human systems.

On a personal level I believe this journey has been successful, even if frustrating and emotionally stirring at times, and my foremost desire, as a post-structuralist, is to continue to engage with more meaningful action; it will not be an easy challenge. The comment of Dumont Jr. (2008) reverberates in my self; *“Political success will only come with an increased focus on discursive warfare”* (2008:201). Is this the drastic course of action for those who inform public sector discourse must pursue?

The chapter opens with of a reflective view of my findings with regard to the three main themes of my research (Page 11) and asks what this means for secondary care management practice and the direction of further academic exploration. I follow this by considering the appropriateness of my theoretical stance and then retrospectively evaluate the success of my methodological approach. The final part of the chapter is a self-reflection of the path my self has travelled during this thesis from its naïve beginnings and to ponder the ways in which this research and the many agents, both practitioners and scholars, with whom I have interacted have influenced the (re)constitution of my self.

### **Reflecting on the Aims of the Research – *High Noon***

This study focuses on three themes that each explores the socio-political relationship between discourse, knowledge, the self and power. The first theme poses the question; “*Do mechanisms of power, exercised through managerialism, attempt to maintain discursive closure in favour of a particular reality of secondary care*” (Page 11). My findings reveal how at all scales of the CES, as each agent tells their stories, the discourse of managerialism becomes a ‘narrative in progress’ as statements serve to create a particular reality of secondary care, as inefficient and failing, by reinforcing the performative imperatives of the Trust Board minutes (3, par 36-1030; 4, par 277; 6; par 166, 8, par 10; 6, par 101) and the impositional power/knowledge of a managerial discourse (1, par 128, 230, 408; 2, par 112, 132, 247; 5, par 56; 8, par 44-56). My findings also strengthen the academic concerns regarding managerialism in the NHS (Haynes, 2003; Klein, 2007; Learmonth, 2006; Learmonth and Harding, 2004; Matthews, 2004; Matthews and Thomas 2007; Thomas, Liddle and Matthews, forthcoming; Pollitt, 2000; 2003; Stacey and Griffin, 2006; Timmins; 2007) and demonstrate that the clinical level voice is marginalized (2, par 105; 4, par 259-267; 7, par 56-67) as discursive closure shifts the relations of power between clinicians and managers (Dent and Whitehead, 2002; Exworthy and Halford, 1999; Gilbert, 2005; Rose, 1999a; Young, 2000).

In terms of performance management I am surprised that, although discursive dominance is reiterated through practice, there is little mention, by clinicians, of the need to meet targets, especially as achieving clinical targets is a clear imperative of the Directorate Manager (3, pars 605, 995, 1003, 1066, 1149; 4, par 243) and voiced every month in the Trust Board minutes. However, clinicians do remark how targets skew resources (4, par, 243, 263; 8, par 56) and the knock-on effect of legitimising a performative focus is evident, especially in terms of implementing a scientific approach of *lean thinking* (1, par 72-103; 2, par 27-36, 112, 146; 3, par 30; 4, par 164; 5 par 112, 214) to patient care, with the aim of *getting patients through the system* (4, par 277) and reducing *delayed transfers of care* (2, par 36). The assumption of managerialism is that patient care and throughput can be controlled and an obvious example, with regards to the futility of applying linear thinking to the complexities of patient care, is the

computer-based system (1, par 30; 2, par 27-36; 3; par 30) that focuses solely on throughput but, can only proceed in one direction and thus totally neglects the indeterminate nature of a patient's prognosis (7, par 110).

The way in which the task-based focus of scientific management is influencing the clinical discourse is expressed vigorously on several occasions through stories relating to audit, risk assessment, patient mealtimes, medication rounds and the fragmentation of the nursing role into specialised positions (1, par 72; 2, par 112-132; 5, par 112; 249). For me, the way Mary (2, par 146) plainly and powerfully sums up what linear thinking, de-professionalisation and the task based focus portends for nursing practice and individualised care must raise a huge concern for the future of secondary care management, even if only because of the frustration and anxiety generated in those who believe their standards of care are coming under threat. I trust that as a reader you can recognise what this could ultimately mean for individualised patient care, perhaps your care.

With regard to the second theme, "*In what way does the reality presented by the discourse of managerialism impact on the inter-discursive constitution of an agent's self?*" (Page 11) I consider that the reconstitution of the participant self is exposed through abundant stories that orientate around delays in patient discharge. These indicate that performativity is becoming an everyday and dominant aspect of health care life, transforming the operational level discourse, but causing anxiety, frustration, a loss of local autonomy and thus flexibility (2, par 36, 94, 2a, 3, par 30, 374; 5, par 40, 112; 6 par 62). Stories clearly demonstrate how the dominant statements of performativity are reconstituting the selves of agents, modifying the normative 'rules' of the field and influencing or distracting their discursive practice in ways that appears to counter the naturally adaptive nature of the secondary care context.

I sense that, in particular, clinical level knowledge represents the 'Achilles heel' of managerialism, perceived as standing in opposition to a web of discourses that impose systematicity, conformance and surveillance and which philosophically de-humanise both the agents and the patients in the system by a mechanistic approach that attempts to attain order through the control or

eradication of agency. By attempting to subordinate the influence of clinical knowledge in the self, discourse is diminishing the prospect of co-evolving ‘managerialism’ to accommodate clinical privileges. The consequent subjugation generates a philosophical position that sustains the context as a closed and dichotomous structure and the expectation of rational authority. Paradoxically the more clinicians ‘debate’ the performative agenda the more dominant the construct becomes in their selves displacing the values that are deeply ingrained in the fabric of the ‘clinical soul’.

However, my third theme asks, “*Does the context reveal the existence of competing, dominant and marginalized discourses at the micro-level, in what ways are these legitimised, tolerated or resisted by agents and to what extent does this impact on their practice*” (Page 11). The findings demonstrate that competing claims are being raised, in an attempt to emancipate the clinical voice. What can be observed, however, and this phenomenon would be predicated by a CES, is that adaptive and co-evolutionary behaviour is being maintained in the face of discursive closure (2, par 68, 136, 227, 297; 3, par 284, 372; 4, par 136) although one must wonder at what price and for how long agents will be able to negotiate an acceptable pathway through the many competing claims.

The story regarding the consultant’s request to lie about the access to facilities, although articulated in an amusing manner, expresses the frustration of having to compromise patient care under the shadow of an economic discourse, but simultaneously raises alternative bodies of knowledge that emancipate the clinical voice (2, par 68). Another statement, whilst believing in the power of the ‘professional ethic’, raises the concern about the ability to keep adaptive practice active; “*I think there is an idealism that comes from nursing, within every profession...about what you are trying to achieve and this gets lost somewhere when you keep trying and trying*” (6, par 148).

This comment signifies that, in my context, the ability of agents, both managers and clinicians, to negotiate a compromise is becoming radically distorted as the power relations prescribed by discursive closure ‘disappear’ (Fletcher 2001:6)

their voices, through marginalisation (4, par 259-267; 7, par 56-67). This interpretation of the context is further supported by the consultant's contention that commissioners 'disappear' information and opinion that does not align with commissioning obligations (7, par 56-67, 74) indicating that it is not merely nurses' voices that are being subjugated.

### **The Necessity of Moving Beyond Modernism - *Ghostbusters***

The findings support Jacobs' (1993) assertion that the modernist privilege of political discourse is clearly dictating the way in which the health care system should function and it is this point that is ripe for debate. Managerialism is the symptom of political interference and provides the discourse through which the secondary care system is being rationally, linearly and mechanistically re-designed to fit this façade; statements of both political and managerial discourse seem to completely neglect the way in which the secondary care system operates in reality as an highly connected and interdependent organisation even though it's workforce, both clinicians and managers, seemingly struggle to maintain this way of operating.

Whilst I have attempted to focus on managerialism, as the major discourse for exploration identified in my opening chapter, the research discovers the existence of a web of interdependent discourses, some of which were quite unexpected, subtly but intricately bound to secondary care governance and impossible to neglect. It is a major misconception of mine that the discourse of managerialism could have stood in isolation and consequently demonstrates the futility of reifying the 'research question' within an open system. In no uncertain terms this point adds to the aim of this critical inquiry in generating an alternative ontological perspective and exposing the assumptions around which managerialism needs to function; organisational stability.

For example, my findings elucidate how unexpected discourses, such as the surveillance mechanisms of the Community Health Council (CHC) interact (1, par19-32; 2, par 78-82; 5, par 99; 7, par 204; 119; 8, par 319) benignly and possibly unconsciously bolstering dispoitif power by legitimising the image of failure, inconsistency and the need for oppressive and prescriptive political tools

of regulatory control. Stories describe how CHC discourse mandates a relationship of surveillance that their members reinforce through practice, such as unannounced visits and patient interviews. Jane's story about the request of the CHC to interview *medical outliers*, (5, par 119); a position that does not suit either patient or medical staff, demonstrates how CHC practice concomitantly acts to humiliate the Trust for its failings whilst supporting the political notions of service variation and discontent.

The same is true of the discourses informing social care (1, par 128; 3, par 34, 60-68, 309; 7, par 204), European Working Time Directive (2, par 161, 7, par 40-72), Modernising Medical Careers (7, par 52-72; 8, par 104) medical litigation (3, par 76, 178, 491; 5, 237) media publicity (3, par 503; 5, par 266) racial issues (09-07) the CBI (05-07) and even the weather (03-07 par 51); their unexpected emergence would have been precluded by my subjective position within the secondary care context, but their effect is extant in the interviews. Liam's remarks about Modernising Medical Careers and the Consultant Contract depict a discourse that emerges from a professional trajectory, but bolsters the processes of scientific management through de-professionalisation and by legitimating managerial control over medical activity (7; par 52-72).

James' narrative relating to *litigatory medicine* (3, par 76; 178) discloses how regulatory discourses of control weave irrationally through the health care ecosystem. James explains how a key concern for primary care is to reduce the number of referrals to secondary care, but formalised clinical guidelines for treatment, although superficially removing treatment variance, paradoxically increase the number of referrals, preventing the Trust from closing its boundaries, in an effort to meet targets, as failure to do so could result in litigation.

Maybe I am being overly dramatic, but I consider my findings echo my concluding remarks in chapter four that implies the emergence of an apparatus of dispotif power, where heterogeneous discourses from diverse and unexpected surfaces of the health care eco-system are ingeniously conjoined to



unify a modernist focus that promotes conformity to political imperatives through subtle forms of disciplinary power, such as the notion of professionalism and mechanisms of surveillance, such as performance management. This can be recognised in the clinically legitimised discourses of clinical governance and the profusion of audit that reinforces the uniformity of practice and stifles any innovative thought.

The consequence of the discursive closure pervading secondary care is what Foucault (1972) calls a *density of verbal performances* (1972: 220) where the statement of all agents, at all levels of the system, are becoming saturated by the dominant political and managerial statements of performativity. However, as the relativist episteme of our CES would predicate, agents indicate differing patterns of response, a manifestation of their subjective interpretation. Whilst some, like James embrace this message with alacrity, almost ‘throwing’ patients out of the door (3, par 372), others, like Mary remonstrate their intolerance by seeking support from consultant colleagues (2; par 297) to avert discourse away from performativity and towards a socio-centric discourse demonstrating how discursive practice is influenced by the fractal ‘rules’ of the habitus and the struggle to hold onto an image of health care historically constituted in the self.

Discourses that endorse conformity or complicity through oppressive mechanisms such as regulation, normative control and surveillance from political, managerial and professional angles can only perpetuate the authoritative and dualist structures that my respondents describe, removing intellectual thinking from the front-line. In terms of patient safety, Liz’s story about her medication error (1; par 408) concerns me deeply as it demonstrates how relations of hierarchical power, however hollow in reality, are in danger of returning clinicians to a climate where dialogue on clinical failure is once again perceived as incompetence. The consequent impact of relations of trust does not bode well for a system where interdependent and collaborative working is crucial.

I consider that there is a huge chasm to cross in terms of removing political control from the NHS in Wales, especially with regard to recent ministerial

statements (Hart, 2008). What is essential for managers and politicians to acknowledge are that discourses that adhere to realist notions of conformity whether through hegemonic or disciplinary control can only engender system stability and inaction, a state of equilibrium that manifests as system stagnation and this will never generate the innovative, flexible and safe environment that the politicians desire and the public need. Foucault's understanding of the productive nature of power through agency elaborates why adaptive and innovative practice is struggling to emerge and co-evolve in a secondary care organisation that is, ontologically, an interactive and interdependent CES.

Foucault's socio-political perspective of discourse can inform management discourse by revealing that a locally negotiated 'discursive unity' is powerful in its ability to build in influences from many discourses, but I consider that this research exposes how this ability is being stifled by a discourse that seeks, conformance, homogeneity and stability. Politicians, nor managers, should not fear the plurality of agency or see it as destructive, but as an innate organisational characteristic that optimises the capacity of power/knowledge (Foucault, 1980) in a CES where diverse influences and local negotiation generate new order.

Political discourse must acknowledge how the unification of power relations, wrought through dispotitif power, removes the prerequisite tension that a CES requires for collaboration and negotiation and where diverse prerogatives can continually jockey for position, co-evolving diverse values and belief systems (Foucault, 1984). Yes, there will be conflicting values as political, managerial and clinical imperatives interact, but it must be understood how the performative prerogative, as a valid health care concern can be integrated with professional and clinical privileges through influence rather than through mechanisms of control, nurturing new ways of thinking and working.

The current approach to health care management is impoverished in its realist perspective of agency and it essential that NHS management discourse moves beyond the dualist and reified ontology to enable co-evolutionary practice at the micro-level. Understanding the philosophical appropriateness of the discourses

of Complexity can begin to accommodate and accept the advantages of heterogeneity and the dynamic and ambiguous nature of an interactive human system and reap the benefits of harnessing the power effects of plurality through a democratic and phronetic process.

### **Thoughts for Future Research – *Never Say Never Again***

I apologise for the weakness of my self, caught within the strictures of binary opposition, but I want to express how completing this thesis generates the extremes of joy and loss. To me, it is an ‘affair’ in which my self is emotionally fixated and I do not want to allow closure. Besides, I sense that this research has merely scratched the surface of an immense web of interactive players in the health care eco-system and the sincere desire to continue to act as advocate and agitator is intense.

My original thoughts had been to look only at the clinical levels of secondary care, but expanding my study to the non-clinician aspects of the acute care sector did serve to demonstrate a how the dominating statements of discourse do circulate through all levels of the organisation and allowed me to explore differentiation in more detail. Removing the clinical boundary allows me to recognise how managers are similarly becoming the ‘puppets’ of political discourse. The narratives of both the nurse (2, par 161), consultant (7, par 56-67) Medical Director (8, par 56) and general manager (4, par 291-310) align with my analysis of the Trust Board minutes that imply that managers are functional, merely implementing political strategy.

The study has identified several promising avenues along which I could continue my journey. Certainly I sense the *creeping erosion* that Seddon (2005) recognises as threatening clinical autonomy and judgement and I consider that this is significant, in nursing practice, in particular, and requires a much deeper investigation to reveal the need for strategies to preserve individualised standards of care. I am also interested in looking at more depth at the public voice, especially with regard to the strategic effect of the Community Health Council. However, the reforms of the health care eco-system currently underway in Wales and the ‘merging’ of primary and secondary care

organisations also presents a fascinating and fertile ground for exploration especially with regard to whether the voices of each sector can be brought together in harmony. The current implication is that the commissioners ‘call the tune’ with regard to prioritising health care needs, but I believe this is mislead as commissioners are placed in a functional relationship with regard to political discourse. It would be fascinating to explore whether the removal of the ‘market-based’ model actually changes the relations of power or whether political voices will continue to act as authorities of delimitation (Foucault, 1972).

On the other hand, my moving into the primary care sector has unearthed another world of surveillance with regards to the monitoring of General Practitioners (GP) activity. The establishment of the Quality and Outcome Framework (QOF) (Department of Health, 2008) for GP services was dubbed as “*a pioneering approach to improving the quality of care by rewarding GP practices for the quality of care that they provide...*” (2008: 2) but presents a political discursive mechanism of surveillance. My concern is the way this is affecting the clinical judgement and autonomy of clinicians and impacting on the treatment of patients. From my position as a clinician in a primary care organisation I subjectively perceive the QOF as dissipating clinical care and would pursue this subject using a similar research strategy with the aim of once again stimulating novel and profound dialogue about the political governance of primary care systems.

### **Reflecting on the Theoretical Framework to this Thesis - *Look Back in Anger***

What I have tried to illuminate, in this thesis, is a way of thinking about the agents in the secondary care system that celebrates their multi-vocality and stresses how the ‘autonomy’ of their practice can engender transformational practice and emergent order. By critiquing the realist limitations that inform traditional philosophies of management and the assumptions innate in the discourses of disciplinary control and surveillance, my research demonstrates through their *density of verbal performances* (Foucault, 1972: 220) that the dominant statements of governance constrain and distort the practice of a

discursively constituted CES by privileging particular bodies of performative knowledge. Although managerialism is a continually evolving discourse the powers of discursive closure removes the ‘freedom’ of agency and thus the internal dynamic to self-organise and co-evolve the competing imperatives that emerge from many surfaces. The modernist assumption is that only agent conformance will attain performance management targets and thus the aspirations of politicians, in a predictable manner. Achieve them they do but at what cost to patient care.

By ontologically (re)conceiving the system as a Complex Evolving System located within a post-structural and relativist episteme, the emergent framework accommodates the uniqueness and subjectivity of an agents position in the system and accepts the diversity generated by the multifarious perspectives witnessed in the stories of my respondents. The discursive complexity of the secondary care system is verified by my rather intricate and lengthy findings, but confirms Bourdieu’s historical and evolving portrayal of habitus locked together with the legitimised fractal ‘rules’ of the field, generated through experience and practice, forming points of stability within the chaos of diversity. This point is particularly emphatic in those who recall health care prior to the insurgence of linear and scientific discourse. This inter-discursive co-evolution is epitomised by the clinical governance manager who has absorbed the need for processes of surveillance and documentary detail, but has blended this with a ‘client’ focus and the need to *get involved*. As Jane suggests; “*its very difficult not to because when someone is angry, they’re complaining, and I want to put it right*” (5; par 399-450).

My findings also portray, in detail, the detrimental consequences of adopting realist frameworks where rational and scientific mechanisms attempt to generate conformance, but remove the local ability to negotiate (2; par 146), although as my framework suggests local action is not removed, agents have not become passive, but continue to act to preserve their habitus and the dispositional status of their hexis (2; par 297; 3; par 372). Whether this engenders negotiation, inaction or manipulation, the findings indicate that agents will jockey for position, using the power/knowledge of their own fields in an attempt to self-

organise practice and re-open system boundaries to sustain optimal standards of patient care. The advantage of the merging a Complexity discourse with current management discourse is that it allows this idiosyncratic behaviour to be optimised in a positive way rather than through a realist lens that attempt to ‘manage’ out their diversity or see it as detrimental.

However, with regard to my earlier remark, that the boundaries to my research had been breached makes me realise my own philosophical frailties and exposes a realist and structuralist dimension in the constitution of my self. It is as though Foucault’s (1972) closing remarks are directed solely at me; “*throughout this book you have been at great pains to dissociate yourself from structuralism*” (1972: 219) and I wonder if throughout this thesis, as I attempt to challenge and critique discourse, I have simply (re)constructed discursive unities around particular bodies of knowledge.

For me, my enlightenment started with James’ critique of the differentiated budgets between health and social care. I became anxious that our discussion was not relevant to managerialism, however, retrospectively, I realised the structuralist limitations of my own thinking; my subjective experience of the health care system had perpetuated difference between the various sectors of care; I myself re-establish the dichotomy and difference by defining the concept of managerialism and of acute secondary health care around specific referential truth claims. Although I recognise the quasi-structuring and the fractal and evolving patterns around which discursive practice orientates, my thematic discussion reduces it and (re)formalises the boundaries between the sectors and roles in a way that I sought to challenge.

Perhaps to clarify my expression, we must look at this from an alternative angle. When you are a patient you do not see boundaries, you naturally see an open system, you cannot see the difference between the defined objects of managers and clinicians, health and social care, or primary and secondary care, you simply want what is best for you, you don’t care which sector is providing or paying for it. Of course, it is ‘we’, situated as service providers and political advisers, who inform service users of where the boundaries lie, we reinforce our own

discursive unity. For us it is a ‘necessary evil’, perhaps an autopoietic survival instinct, because those providing services are constrained by budgetary models, but this dissipates any likelihood of synchronisation or co-evolutionary practice. I ponder whether politicians would benefit from thinking about the ‘welfare’ eco-system in this holistic and interactive manner that can remove the barriers and definitions between sectors.

### **Validating the Methodological Approach for My Context – *Shadow of Doubt***

Focusing on the socio-political aspects of discourse, this research adopts a critical and phronetic position to explore the power relationships through which secondary health care is defined, examining the relationships between discourse, knowledge, self and power using Foucauldian discourse analysis. The findings demonstrate that this post-structural methodological approach is effective in emancipating phronetic knowledge and in demonstrating the polyphonic, dynamic, open and evolving ontology of the context, the historic and experiential constitution of the respondent’s self and that multiple and fluid subjective perspectives exist simultaneously. As each story is told the underlying discourse (Foucault, 1972) or narrative (Boje, 2001) emancipates their claims to truth as each agent speaks with a unique and valid voice. Jane’s interview, in particular, demonstrates how the self is constituted by a tangle of discursive statements that flow between several unities.

The approach also reveals how an agent self orients around a quasi-structured discourse or fractal rules that are historically wrought and expose how the dominant statements of governance suffuse the habitus of my respondents. Their narratives frequently infer a breach of ideals (Reissmann, 1993), but indicate that the dominant performative perspectives of secondary care reality are modifying the constitution of their selves and their consequent discursive practice within this hyperreality.

Foucauldian discourse analysis also provides the space for me to locate my self in the inquiry accepting my interdependency with the secondary care environment. Bringing my own voice into the research process adds my self as

another dimension to the findings and acknowledges that, like my respondents, my subjective interpretation is filtered through the strictures of my self and its historical constitution. This deliberation validates my contribution to knowledge through this process and explains why I allow my respondents to speak for themselves to avoid my potential distortion of their discursive claims.

With regard to the suitability of my Biographical-Narrative Interview approach, the *self as instrument* technique (McCracken, 1998) worked well and I was able to match many of their stories with my own experiences, even though the dilemma of interpretation is not necessarily removed and indeed may be enhanced towards my own bias. I was encouraged to note how Boje's analytical ideas held true. Indeed I could recognise how the narrative followed the story, as if to reinforce on me the reason for its telling.

The open format of the interview provides space for agents to speak and to lead the direction of the interview, however, the use of such an open format, at times, perhaps mixed with my naïve skills, generated unease as I found that not all agents are able to provide stories in a freely flowing manner and without prompt. The findings demonstrate the unpredictable nature of the responses and the ability of some to talk more than others. Liam, I remember as particularly amusing in the way he expected me to lead the direction of the interview and this interaction had to be handled with care so as not to drive its content. The converse is also true and reflects McCracken's (1988) warning that the "*really open ended interview is an ever-expanding realm of possibility in which the generative power of language is unleashed to potentially chaotic effect*" (1988:25).

Another dimension of the interview format with which I was not comfortable was regarding the probing technique. The first interview highlighted the distraction of noting key words, as the respondent sensed my interest in a particular topic and potentially distorted the flow of the story and I therefore did not continue with this approach in the following interviews. Another suggestion by Wengraf (2001) and McCracken (1988) is that probing can be left to the end of the interview, but again this technique felt awkward. To revisit a 'subject'



perhaps an hour after they had completed their storyline makes the assumption that the respondent would remember the reason for its telling and at times may have appeared a little morbid or voyeuristic. As McCracken (1988) concurs, the contingent and flexible approach allows me to take full advantage of any opportunity that may arise and I do not feel any adaptations made have detracted from the methodological objectives as my aim was to generate freely flowing stories of the respondent's choosing.

Consequently my interviews are diverse, in their emergent format, where some expected and perhaps wanted a more interactive conversation than others who were prepared to speak ceaselessly for hours. Regardless, I felt that this method was suitable and appropriate vehicle that allowed my respondents the space to emancipate their truth claims, unburden their anxieties and for me to explore the relationship of power and knowledge within their underlying narrative. Thus I would consider this approach for future research into the socio-political dynamics of discourse and discursive practice.

### **Reconstituting the Researcher's Self – *The Bride of Frankenstein***

*“Writing is not merely the transcribing of some reality...but a process of discovery: discovery of the subject ...and discovery of the self”* (Lincoln and Guba, 2003:284).

I feel pride and a sense of satisfaction as I complete this piece of work. It has been an immense challenge, although one that I have welcomed in my life, and it is perhaps impossible for its substance not to have triggered a profound effect on the (re)constitution of my self. The project started life as an educational undertaking with a desire to promote alternative ontological perspectives of the secondary care organisation and to reflect on how the discourse of managerialism posed a radical disjuncture with the prevailing philosophy of clinical level practice. However, as I declared in the opening chapter, this research is also a personal quest, intensely inspired by my emotional experiences of the power innate in managerialism and this section allows me the freedom to re-examine this phase of my life. I believe my findings have supported my prior concerns of the way in which the discourses of

managerialism distort and distract clinical and professional practice, but it is to reflect on how this research has influenced my self at a deeper and more personal level to which I now turn my thoughts.

As I set out on this journey I was a secondary care clinician and manager whose hexis had suffered from dominant and seemingly incompatible statements wrought through a managerialist discourse and the consequential marginalisation and exclusion of my voice, regardless of the validity of its referential knowledge. I sensed that relations of power were shifting away from the relational and collaborative values that I cherished; perceived as weaknesses in the face of managerialism. I was enduring an emotional roller coaster of experiences not only new to me, but also over which I seemed to have little or no control. I felt as if I was suffocating. The imagery expressed in the lyrics of *Submarine* (Shaw, 2009), a song composed by a close friend of mine could have been written for me, as they metaphorically express the suffocating pressure caused by the changing dynamics of power; “*I used to be captain, but now I’m the cabin boy*”. My opening chapter thus employed an apposite expression from the *Gospel According to Saint Luke* of what I needed to achieve for my self to move above and beyond this experience; “*Physician heal thyself*” (4:23). At the time I had no means of making sense of what was happening to me and I felt as if the victim of a personal conspiracy.

As my journey commenced my theoretical explorations of the literature surrounding management, sociology and power significantly informed my intellect allowing me to theorise on the circumstances in which my self was located. The thoughts of great scholars allow me to understand the relativist and subjective nature of my reality and to picture the discursive power effects to which my self was, and still is, subjected. As I acknowledged earlier, embarking on a study of power can be unnerving as it forced me to revisit and examine that emotional phase of my career. I now understand what Lipp (2003) is saying; that being aware of oppression allows one to become conscious of that oppression and the need to act to rectify the imbalance wrought. In all honesty, I am not sure this has alleviated my anguish, as I still do not feel I am in a position to act with any gusto, but the unconscious of my self is certainly awakened to

workings of the power/knowledge dynamic that exist within the NHS discourses of discipline, surveillance and control.

The reflexive methodological strategy employed in this study, however, provides a space for me to palliate my self by directly confronting and interpreting the experiences of other agents in the secondary care system. As I immerse my self in their accounts of secondary care events many stories are presented with which I can match my experiences and reflect how discourses of managerialism disrupt processes of care, shifting the balance of power, subjugating the clinical voice and engendering an environment of conformance and surveillance. I found this mirroring process emotionally draining at times; I felt empathy, maybe sympathy, as if a common bond with the participants had been generated. As my journey continues through the methodological jungle, I consider that my choice of the biographical interview method has been a just platform from which to launch an emancipative and advocatory stance. Not only does the method provide a critical stage, on which to reflect upon my own experiences, it simultaneously allows my participants the space to re-define the reality of secondary care life.

I believe my findings reveal the dominance of modernist statements throughout the secondary care environment, rhizomatically circulating through all scales of the system; these statement did not act merely on my self, as by replicating the dominant paradigm of management discourse they reconstitute every self, both my colleagues and my managers, although I discern, that at times, other agents similarly experience the suffocating pressure of this modernist discourse. By acting as advocate I hope to emancipate this knowledge, through this piece of work and to expose, as Denzin and Lincoln (2005) suggest, the ways in which we are all becoming trapped by the strictures of a modernist body of knowledge. The authors argue that by exposing these relations of power, it allows us to continually challenge the misfortunes of their myopic reality.

However, as I author this final stage, I ponder whether my self desperately needed such confirming evidence and sought to find it in the lives of others, but I hope that, as the reader, you can balance this thought by reflecting and

interpreting on my respondents stories as told in their own words. Greene (1980) contends that; *“writing is a form of therapy; I wonder how all those who do not write, compose or paint can manage the melancholia, the panic fear, which is inherent in every situation”*. To compare and reiterate their experiences with my own have to some extent, allowed me to dissipate the notion that I had been singled out by recognising others who express similar anguish in their stories. This last statement in ethical terms, implicates deontological issues that I perhaps had not considered earlier, but I hope that by allowing them to raise their voice, through my writing, that this thesis has created a platform and empowered them to challenge and critique the illusion of power that others seek to impose.

However, I also met and acknowledged, with fervour, disconfirming evidence within my context, where my respondent’s stories breached my expectations as I met with managers are able to co-evolve the statements of managerialism with the clinical and professional claims to truth and this reassures me that management discourse can co-evolve in a more participative and collaborative direction. For me, the barrier to this necessary transformation is the continuing political support for realist philosophies of management that advocate control and surveillance through endless processes of performance management. With this in mind I am encouraged to continually challenge the status quo and will pursue this critical line of inquiry in my future research.

Four years have now passed and friends and colleagues remark that that my confidence has returned and that I have ‘mellowed’ and I agree that with their generous support and encouragement the ‘phoenix has risen’, wings a little blackened, but to what extent this can be attributed solely to this research is difficult to judge. At the same time as I started this thesis I left the secondary care context, in which I worked, to move into the primary care sector. The relief I felt was immense and the respect I received in my new role slowly restored my belief in my abilities.

However, rarely a day goes past where I do not reflect on my past; my experiences historically constitute my self and cannot be undone. This constant

reminder is partially exacerbated by the research and my findings chapter elaborates on my emotional ties with the secondary care environment. My keeping in touch with past colleagues, several of whom also suffered alongside me, has certainly prevented me from forgetting my past and on keeping these experiences alive. As Boje (2001) contends storytelling is a never ending self-reflexive search for meaning and voicing our experiences remains a significant part of our conversation in an empathetic bid to support our sense making. To this day I regret my having to leave the secondary care sector, but although the torment has settled the frustration remains and I sometimes sense that in some ways I resurrect the memories, defiantly refusing to allow my experiences to be mollified. Besides appeasement, in my mind, could only dissipate the challenge I have set myself, to transform the modernist discourse in which the public sector is entrenched.

So where do I go from here, I must move on from my state of anguish, I must not fear this challenge; it is fear that can obscure your future. I am the auteur I can re-direct the scene and re-write its ending; my self can and must escape the mourning process in which I linger. As a final indulgence I reflect on the experiences of *Apollo 13*; they may have been prevented from walking on the moon, but they lived through their experience to fly another day. I close this self-reflection with the words of Jim Lovell (1995); "*Gentleman it's been a pleasure flying with you*" (IMDb, 2008).

### **Final Comment – *Never Say Goodbye***

This has been an ambitious project, but the generation of phronetic knowledge has been successful in meeting the object of the inquiry, identifying the complex maze of discourses that constitute the secondary care environment, in Wales, and by revealing how discursive closure employs particular mechanisms of power to reinforce a particular image of secondary care reality. By exposing these discourses of power and surveillance to my readers I trust that the study emancipates subjugated voices and opens eyes to the strategic exercise of political power. Therefore, I hope this thesis is able to entertain, what Donaldson (2007) contends is, a *social-life* (2007:3) through its reading and telling, and I hope that its contentious revelations will provoke debate about the need to

(re)generate a progressive philosophy of management by continually challenging the way in which those who serve the interests of the secondary care field in Wales are becoming inscribed by discourses that privilege modernist claims.

I have tried to illuminate throughout this thesis a new way of thinking about the agents in the secondary care organisation that celebrates and harnesses their plurality, where diversity engenders an ‘edge of chaos’ environment for the spontaneous transformation of practice. This research demonstrates the inevitability of agents to self-organise, but advises that productive nature of this spontaneous process must be influenced in a way that co-evolves NHS discourse, in order to meet the multiple demands made on it by its various stakeholders.

My critical approach has challenged the limitations innate in managerialism and their constrained view of human agency that neither acknowledges nor copes with the complexity of the human social system. By introducing an alternative strand of intellectual thinking to management discourse I hope to highlight that re-conceptualising the secondary care system as a discursively constituted CES can accommodate the idiosyncrasies of agency and engender a perception of emergent and spontaneous order that permits discourse to eliminate mechanisms of control and surveillance.

My final commentary is to leave you to ponder the words of Foucault (1999);

*“I have no way of knowing how people will interpret the work I have done...I believe that the freedom of the reader must be absolutely respected”* (1999:111).

## References

### A

Abercrombie, N., Hill, S. and Turner, B. (1980) *The Dominant Ideology Thesis*, Allen and Unwin, London

Adams G.B. and Ingersoll, V.H. (1990) *Culture, technical rationality and organisational culture*, *American Review of Public Administration*, December, 20 (4) 285-302

Adcroft, A. and Willis, R. (2005) *The (Un)intended outcome of public sector performance measurement*, *International Journal of Public Sector Management*, 18 (5) 386-400

Adler, P. (2004) *Chapter 15: Market, hierarchy and trust: the knowledge economy and the future of capitalism*, in Starkey, K. Tempest, S. and McKinlay (Eds) *How Organisations Learn: Managing the Search for Knowledge*, 2<sup>nd</sup> Ed. Thompson International Publishers, Padstow.

Adler, R. and Elmhorst, J. (1999) *Communicating at Work: Principles and Practices*, 6<sup>th</sup> Ed, McGraw-Hill Co. Inc. US

Agar, Michael (2005) *Telling it like you think it might be: Narrative linguistic anthropology and the complex organisation*, *Emergence: CO*, 7 (3-4) 23-34

Akella, D. (2003) *A Question of Power: How does management retain it?* *Vikalpa*, 28 (3) July –Sept 2004 pp 45-56

Alcolado, J. (2000) *Nurse Practitioners and the Future of General Practice*, *British Medical Journal*, 320 1084

Allen, Amy (2000) *The Anti-Subjective Hypothesis: Michel Foucault and the Death of the Subject*, *The Philosophical Forum* XXX1 (2) 113-130

Allen, P. (1997) *Cities and Regions as Self-Organising Systems: Models of Complexity*, *Environmental Problems and Social Dynamics Series*, Volume 1, Gordon and Breach, Reading

Altheide, D.L. and Johnson, J.M. (1998) *Criteria for assessing interpretative validity in qualitative research* in Denzin N.K. and Lincoln, Y.S.(Eds) *Collecting and Interpreting validity in Qualitative Research*, Thousand Oaks, CA; Sage

Althusser, L. (1984) *Essays on Ideology*, London, Verso

Alvesson, M. (1993) *Cultural perspectives on organisations*, Cambridge University Press, Cambridge

Alvesson, M. (1991) *Organisational Symbolism and Ideology*, *Journal of Management Studies* 28 (3) 207- 225

Alvesson, M. and Deetz, S. (2000) *Doing Critical Management Research*, Sage London.

Alvesson, M. and Wilmott, H. (1992) *Critical Management Studies*, Sage, London,

Alvesson, M. and Wilmott, H. (1996) *Making Sense of Management: A critical introduction*, Sage, London

Anderson, R.A. and McDaniel Jnr, R.R. (2000) *Managing Health Care Organisations: Where Professionalism Meets Complexity Science*, *Healthcare Management Review*, 25 (1) pp83-92

Anonymous (2008) *For those who love Picasso as I do (a critique) Les Demoiselles d'Avignon*, posted Saturday 26<sup>th</sup> July, 2008 <http://people.tribe.net/30498b43-aca1-461c-a464-c23bea897c50/blog/242ba47d-e883-432e-9638-f17e584578a7>

Arendt, Hannah (1970) *On Violence*, Allen Lane, London.

Arnold, John; Coombs, Crispin; Wilkinson, Adrian; Loan-Clarke, John; Park, Jennifer; Preston, Diane (2003) *Corporate Images of the United Kingdom National Health Service: Implications for the Recruitment and Retention of Nursing and Allied Health Profession Staff*, *Corporate Reputation Review*, 6 (3) 223-238

Arthur, B.W. (1995) *Increasing returns and path dependency in the economy* <http://business2.com/articles/mag/o,1640,37570,00.html>

Arthur, B.W. (1990) *Positive feedbacks in the economy*, *Scientific American*, 262, February, 92-99

Ashby, W.R. (1956) *Introduction to Cybernetics*, Wiley, New York NY

Aristotle (1991) *The Art of Rhetoric*, Penguin Classics, London.

Atkinson, R. (1998) *The Life Story Interview*, Sage, London

Audit Commission (2008) *Is the Treatment Working? Progress with NHS System Reform*, June 2008, Audit Commission Publications, Wetherby.

## **B**

Bahktin, M. (1985) in Luhmann, John, T. (2005) *Narrative Processes in Organisational Discourse*, *Emergence: CO*, 7 (3/4) 15-22



- Bakhtin M. (1970) in Hirchkop, K. and Shepherd, D. (2001) *Bakhtin and Cultural Theory*, 2<sup>nd</sup> Ed. Manchester University Press, Manchester
- Bak. P. (1996) *How Nature Works: The Science of Self-organised Criticality*, Copernicus, New York, NY
- Bak, P. Tang, C and Wiesfield, K. (1987) *Self-organised Criticality: An exploration of 1/f noise*. Physical Review Letters, 59, 381-384
- Baker, Mark (2000) *Making Sense of the NHS White Papers*, 2<sup>nd</sup> Edition, Radcliffe Medical Press, Oxon
- Banham, L. and Connelly, J. (2002) *Skill mix, doctors and nurses: substitution or diversification?* Journal of Management in Medicine 16, (4) 259-270
- Barker, J. (1993) *Tightening the Iron cage: concertive control in self-managing teams*, Administrative Science Quarterly, 38, (3) 408-437
- Barr, Nicholas (1998) *Towards a Third Way: Rebalancing the role of the state*, New Economy, 5, (2) 73-76
- Barry, D and Elmes M (1997) *Strategy retold: Toward a narrative view of strategic discourses*, Academy of Management Review, 22, 429-452
- Barthes, Roland (1963) in Davis, C. (2004) *After Poststructuralism: Reading, Stories and Theory*, Routledge, Oxon
- Barthes, R. (1989) *The Rustle of Language*, Hill and Wang, New York, NY
- Barthes, R. (1971) in Czarniawska, B. (1998) *A Narrative Approach to Organisation Studies*, Sage, London
- Bar-Yam, Y. (2005) *Making Things Work: Solving Complex Problems in a Complex World*, NECSI Knowledge Press, Cambridge, MA
- Bar-Yam, Y. (2006) *Improving the Effectiveness of Healthcare and Public Health: A Multi-Scale Complex System Analysis*. American Journal of Public Health, 96 (3) 459-466
- Baskin, Ken (2008) *Storied Spaces: The Human Equivalent of Complex Adaptive Systems*, Emergence: CO, 10 (2) 1-12
- Baskin, Ken (2007) *Foucault, Complexity and Myth: Towards a complexity-based approach to social evolution (a.k.a. history)*, in Pre-Proceedings of the Third International Workshop in Complexity and Philosophy, Stellenbosch, South Africa, 22<sup>nd</sup> –23<sup>rd</sup> February 2007
- Baskin, Ken (2005) *Complexity, stories and knowing*, Emergence: CO, 7 (2) 32-40

- Bass, B.M. and Alvolio, B.J. (1993) *Transformational leadership and organisational culture*, Public Administration Quarterly, 17, (1) 112-121
- Bate, P. (2000) *Changing the culture of a hospital: from hierarchy to networked community*. Public Administration, 29, 297-308
- Bauman, Zygmunt and May, Tim (2001) *Thinking Sociologically*, 2<sup>nd</sup> Ed. Blackwell, Oxford.
- Beaudrillard (2002) in Parker, M. (2002) *Against Management*, Polity Press, Cambridge
- Beecham, J. (2006) *Beyond Boundaries: Citizen Centred Local Services for Wales*, Welsh Assembly Government. Cardiff
- Beer, S. (1981) *The Brain of the Firm*, Wiley, Chichester.
- Benhabib, S. (2006) *Democracy and Difference: Reflectons on the metapolitics of Lyotard and Derrida*, in Thomassen, L. (Ed) *The Derrida-Habermas Reader*, Edinburgh University Press, Edinburgh
- Berman-Brown, R. and Brooks, I. (2002) *Emotion ant Work: Identifying the emotional climate of night nursing*, Journal of Management in Medicine, Oct 2002 Volume 16 (5) p 327-344
- Bertaux, D. (1981) in Denzin, Norman K. (1989) *Interpretative Biography*, Sage Publications, London
- Billing, M. (2000) *Towards a critique of the critical*, Discourse and Society, 11 (3) 291-292
- Billington, Rosamund; Hockey, Jenny; Strawbridge, Sheelagh (1998) *Exploring Self and Society*, MacMillan Press, Basingstoke.
- Bilton, T: Bonnett, K. Jones, P: Lawson, T: Skinner, D: Stanworth, M: Webster, A. (2002) *Introductory Sociology*, 4<sup>th</sup> Ed. Palgrave, Basingstoke
- Black, Carol (2006) in Wass, Valerie (2006) *Doctors in society: medical professionalism in a changing world: Conference report*, Clinical Medicine 6 (1) Jan-Feb, 109-112
- Black Edwin (1997) *Rhetorics prospects; twenty five years later*, in Enos T. and McNabb R. (Eds) *Making and Unmaking the Prospects for Rhetoric: Selected Papers*, Lawrence Erlbaum Assoc, Mahwah, NJ
- Black, N. (2006) *Editorial: Healthcare Productivity*, British Medical Journal, August 12<sup>th</sup> 2006 333 (7563)
- Blackler, Frank (2004) *Chapter 16: Knowledge, knowledge work and organisations: an overview*, in, Starkey, Ken; Tempest, Sue and McKinlay, Alan

- (Eds) *How Organisations Learn: Managing the Search for Knowledge*, Thomson Learning, London
- Blackman, T. (2001) *Complexity Theory and the New Public Management*, (accessed January, 14<sup>th</sup> 2004)  
[http://www.whb.co.uk/social\\_issues/tbhtm](http://www.whb.co.uk/social_issues/tbhtm).
- Block, Peter (1996) *Stewardship: Choosing Service over Self-Interest*, Berrett-Koehler, San Francisco, CA
- Blomquist, C. (2000) *In the Name of Managerialism : Reforming Organisations in the Swedish Public Sector*, *Administrative Theory and Praxis*, 22, (2) 226-245
- Bloom, L.R. and Munro, P. (1995) *Conflicts of Selves: Non-unitary Subjectivity in Women Administrators' Life History Narratives*, in: Hatch, J.A. and Wisniewski, R. (Eds) *Life History and Narrative*, Falmer Press London
- Blumenthal, D. and Scheck, A. (1995) *Improving Clinical Practice*, Jossey-Bass, San Francisco, CA
- Blythe, J., Baumann, A. and Giovanetti, P. (2001) *Nurses experience of restructuring in three Ontario hospitals*, *Journal of Nursing Scholarship*, 33 (1) 61-68
- Boden, R. Cox, R. and Nedeva, M (2006) *The appliance of science? New public management and strategic change*, *Technology Analysis and Strategic Management*; June 2006, 18 (2)125-141
- Boje, D.M. (2006a) *Book Review Essay: Pitfalls in storytelling advice and praxis*, *Academy of Management Review*, 31 (1) 218-230
- Boje, D.M. (2006b) *Storytelling Organisation* (Accessed 14<sup>th</sup> March 2007)  
<http://peaceware.com/storytellingorganisation/book/index.htm>
- Boje, D.M. (2001a) *Narrative Methods for Organisational and Communication Research*, Sage, London
- Boje, D.M. (1991a) *Consulting and Change in the Storytelling Organisation*, *Journal of Organisational Change management* 4 (3) 7-18
- Boje D.M. (1991b) *The storytelling organisation: A study of storytelling performance in an office supply firm*, *Administrative Science Quarterly*, 36, 106-126
- Boje, D.M. Luhmann, J.T. and Baack, D.E (1999) *Hegemonic Stories and Encounters Between Storytelling Organisations*, *Journal of management Inquiry*, 8 (4) 340-360
- Boje, D.M. and Rosile, G.A, (2003) *Life imitates art: Enron's epic and tragic narration*. *Management Communication Quarterly*, 17, 85-125

- Bolton, S.C. (2004) *A simple matter of control? NHS hospital nurses and new management*, Journal of Management Studies, 41 (2) 319-335
- Bolton, S.C. (2002) *Consumer as king in the NHS*, International Journal of Public Sector Management, 15 (2) 129-139
- Bone, D. (2002) *Dilemma of emotion work in nursing under market-driven healthcare*, International Journal of Public Sector management, April, 15 (2) 140-150
- Bosely, S. (2007) *Junior doctors driven abroad by new system*, The Guardian, March 2nd 2007
- Boulding, Kenneth E. (1956) *General Systems Theory- The Skeleton of Science* Reprinted 2004, Emergence: CO 6 (1/2) 127-139
- Bourdieu, Pierre (2001, orig. 1998) *Masculine Dominance*, Translated by Nice, R. Stanford University Press, Stanford CA.
- Bourdieu, Pierre (1991) *Language and Symbolic Power*, Edited Thompson, J.B., Translated by Raymond, G. and Adamson, M. Polity Press, Cambridge
- Bourdieu, Pierre (1977) *Outline of a Theory of Social Practice*, Cambridge University Press, Cambridge
- Bowers 1987 in Minichiello, V; Aroni, R; Torewell, E; Alexander, L. (1995) *In-depth Interviewing: Principles, Techniques and Analysis*, 2<sup>nd</sup> Ed. Pearson Education, Sydney, Australia
- Boyne, G. (2002) *Public and Private Management; What's the difference?* Journal of Management Studies, 39, 97-122
- Bradshaw, A. (1995) *Nursing and Medicine: Co-operation or conflict*, British Medical Journal, 311, 304- 305
- Brechin, A., Walmsle, J., Katz and Pearce, S. (1998) *Care matters, Concepts, Practices and Research in Health and Social Care*, Sage, London.
- Brenneis, D. (1996) *Telling Troubles: Narrative Conflict and Experience*, in Briggs, C.L. (Ed) *Disorderly Discourse: Narrative, Conflict and Inequality*, Oxford University Press, Oxford
- Bridges, J. Dor, A. and Grossman, M. A (2005) *Wolf Dressed in Sheep's Clothing: Perhaps Quality Measures are just Unmeasured Severity*, Applied Health Economics and Health Policy, January, 4 (1) 55-56
- Briggs, A.J.R. (2005) *Professionalism in Further Education*, Management in Education, 19 (3) 19-23
- British Broadcasting Corporation (2007a) *Can Gerry Robinson Fix The NHS?* Transmitted, January 9<sup>th</sup> 10<sup>th</sup> 11<sup>th</sup> 2007 BBC 2

British Broadcasting Corporation (2007b) *Panorama: Secrets of the Drug Trials*, Transmitted, 29<sup>th</sup> January 2007 BBC1

British Broadcasting Corporation (2007c) *Doctors protest over jobs*, BBC News 24, 17<sup>th</sup> March 2007  
[www.news.bbc.co.uk/1/hi/health/6411481.stm](http://www.news.bbc.co.uk/1/hi/health/6411481.stm) (accessed 10th September 2007)

British Broadcasting Corporation (2007d) *Jobs protest planned by doctors*, BBC News 24, 2<sup>nd</sup> March 2007  
[www.news.bbc.co.uk/1/hi/health/6411481.stm](http://www.news.bbc.co.uk/1/hi/health/6411481.stm) (accessed 10th September 2007)

British Broadcasting Corporation, (2007e) *Newsnight: Medical Morale*, May 21<sup>st</sup> 2007  
[www.bbc.co.uk/blogs/newsnight/2007/05/medical\\_morale.html](http://www.bbc.co.uk/blogs/newsnight/2007/05/medical_morale.html) (accessed 22nd May 2007)

British Medical Association (2007a) *Reviewing training reforms not enough says BMA*, 16<sup>th</sup> April 2007  
[www.bma.org.uk/ap.nsf/content/mtas/60407](http://www.bma.org.uk/ap.nsf/content/mtas/60407) (accessed 10th september 2007)

British Medical Association (2007b) *Guidance on the New Consultant Contract and its implication for job plans (programmed activities)*  
[www.rcplondon.ac.uk/professional/consultant\\_contract/index.asp](http://www.rcplondon.ac.uk/professional/consultant_contract/index.asp) (accessed 10<sup>th</sup> September 2007)

Brockman, J. (1997) *A New Science of Qualities: A talk with Brian Goodwin*, *The Third Culture*, 15, 199

Brooks, I and MacDonald, S. (2000) *'Doing Life': Gender Relations in a Night Nursing Sub-culture*, *Gender, Work and Organisation*, 7 (4) October, 221-229

Brooks, C. and Warren, R.P. (1979) *Modern Rhetoric*, 4<sup>th</sup> Ed. Harcourt Brace Jovanovich Inc. New York, NY

Brown, R.B. and Brooks, I. (2002) *Emotion at Work: Identifying the emotional climate of night nursing*, *Journal of Management in Medicine*, 16 (4-5) 327-344

Brown, C. and Jones, L. (2004) *The Gender Structure of the Nursing Hierarchy: The Role of Human Capital*, *Gender, Work and Organisation*, 11, (1) 1-25

Brown, J. and Minichello, V. (1994) *The Condom: Why more people don't put it on*, *Sociology and Illness*, 6, 229 -251

Bruner, J. (1986) *Actual Minds, Possible Worlds*, Harvard University Press, Cambridge, MA

Bruner, J. (1990) *Acts of Meaning*, Harvard University Press, Cambridge MA

Bryant, M. and Cox, J.W. (2004) *Conversion stories as shifting narratives of organisational change*, *Journal of Organisational Change Management*, 17, 578-592

Burke, K. (1969) *A Grammar of Motives*, University of California, Berkley, CA

Burns, T. and Stalker, G. M. (1961) *The Management of Innovation*, Tavistock, London.

Burrell, G. (2001) *Critical Dialogues on Organisation*, *Ephemera*, volume 1 (1) pp 11-29

Burrell, G. (1998) *Modernism, Post-modernism and Organisational Theory: The Contribution of Foucault*, in McKinlay A. and Starkey K. (1998) *Foucault, Management and Organisation Theory*, Sage London.

Burrell and Morgan (1979) *Sociological Paradigms and Organisational Analysis*, Heinemann. London.

Burton, C. (2002) *Introduction to Complexity*, in Sweeney, K and Griffith, F (Eds) *Complexity in Healthcare: An Introduction*, Radcliffe Press, Oxford.

Burton, Michael and Higley, John (1987) *Invitation to Elite Theory: The basic contentions reconsidered*, in Domhoff, G.W. and Dye, T. (Eds) *Power Elites and Organisations*, Sage, Newbury Park, CA

Bush, Tony (2008) *From Management to Leadership: Semantic or meaningful change*, *Educational Management and Leadership*, April, 36 (2) 271-288

Butler, Andrew (2005) *Film Studies: The Pocket Essential*, Pocket Essentials, Harpenden.

Butler, J. (1990) *Gender Trouble: Feminism and the subversion of identity*, Routledge, London

Byrne, D. (1998) *Complexity Theory and the Social Sciences: An Introduction*, Routledge, London.

## C

Cabinet Office (1999) *Modernising Government*, March 1999, The Stationery Office, London.

Calas, M. and Smircich, L. (1991) *Voicing Seduction to Silent Leadership*, *Organisation Studies*, 12 (4) 567-602

Callaway, H. (1992) *Ethnography and Experience: Gender Implications in Fieldwork and Texts*, in Anthropology and Autobiography, Oakely, J and Callaway, H (Eds) Routledge, London.

Candlin, C.N. and Maley, Y. (1997) *Intertextuality and Interdiscursivity in the discourse of alternative dispute resolution*, in Gunnarsson, B.L: Linell, P. and Nordberg, B. (1997) *The Construction of Professional Discourse*, Addison-Webley Longman Ltd, Harlow.

Cannon Séamus (2006) *The Experience of Strategic Planning and Performance Management in the education sector*, in Stacey, R. and Griffin, D (Eds) *Complexity and the Experience of Managing in Public Sector Organisations*, Routledge, Oxon.

Čapek, Karel (1926) *About Relativism*, in *Apocryphal Tales*, Reprinted 1997, Catbird Press, North Haven, CT.

Čapek, Karel (1923) *R. U. R.* Reprinted 2001, Dover Publications Inc, Dover, NY

Cardiff University (2006) *Undergraduate degree/pre-registration scheme*, School of Nursing and Midwifery Studies, Cardiff University, Cardiff.

Carlisle, Y and MacMillan, E. (2006) *Comparing Paradigms: the case for thinking about strategy and strategy research*. Conference Proceedings, Complexity Conference of Health and Social Care, Milton Keynes, February 28<sup>th</sup> 2006

Carney, M. (2006) *Understanding organisational culture: the key to successful middle manager strategic involvement in health care delivery*, *Journal of Nursing Management*, 14 (1) 6-12

Carney, M. (2004a) *Middle managers involvement in strategy development in not for profit organisations: The Director of Nursing perspective*, *Journal of Nursing Management*, 12, 3-21

Carney, M. (2004b) *Perceptions of professional clinicians on their involvement in strategic planning in health care management: Implications for interdisciplinary involvement*, *Nursing and Health Sciences*, 6 (4) 321-328

Carter, Chris (2008) *A Curiously British Story: Foucault Goes to Business School*. *International Studies of Management and Organisation*, 38 (1) 13-29

Cavanagh, S. and Coffin, D. (1992) *Staff turnover among hospital nurses*, *Journal of Advanced Nursing*, 17 (11) 1369-1376

Chafe (1990) in Reissman, Catherine, K. (1993) *Narrative Analysis*, Sage, London

Chaharbaghi, Kazem (2007) *Provision of Public Services in an Age of Managerialism: Looking better, feeling worse*. *Equal Opportunities International*, 26 (4) 319-330

- Chapman, Jake (2004) *System failure: Why governments must learn to think differently*. 2<sup>nd</sup> Ed. Demos, London.
- Chase, S (2005) *Chapter 25: Narrative Inquiry: Multiple Lenses, Approaches and Voices*, in Denzin, N. K. and Lincoln Y. (Eds) Editors: *The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> Edition, Sage, London
- Chaucer, G. (1387) *The Canterbury Tales*, Reprinted 1951, Penguin, Harmondsworth.
- Checkland, P (1981) *Systems Thinking, Systems Practice*, Wiley, Chichester.
- Cheever, S. (1984) in Denzin, Norman K. (1989) *Interpretative Biography*, Sage Publications, London.
- Chiarella, M. (2002) *The legal and professional status of nursing*, Churchill Livingstone, Edinburgh.
- Child, J. (1982) *Professionals in the Corporate World: Values, Interests and Control*, in Dunkerly, D. and Salaman, G. (Eds) *The International Yearbook of Organisational Studies*, Routledge and Kegan Paul, London
- Child, J (1982b) in Reed, M. (1989) *The Sociology of Management*, Harvester Wheatsheaf, Hemel Hempstead.
- Chia, R. (2002) *The Production of Management Knowledge: Philosophical Underpinnings of Research Design*, in Partington, D (Ed) *Essential Skills for Management Research*, Sage, London
- Chua, W and Clegg, S. (1990) *Professional closure: the case of British nursing*, *Theory and Society*, 19,135-172
- Cilliers, P. (1998) *Complexity and Postmodernism : Understanding Complex Systems*, Routledge, Oxon
- Clancy, Thomas, R. (2007) *Organising: New ways to harness complexity*, *Journal of Nursing Administration*, 37, (12) 534-536
- Clancy, Thomas, R. (2006) *The Benefits of a Standardised Nursing language in Complex Adaptive system*, *Journal of Nursing Administration*, 36 (9) 426-434
- Clancy, Thomas, R. (2005) *Complex Nursing Systems*, *Journal of Nursing Management*, 13 (3) 192-210
- Clancy, T.R. (2004) *Navigating in a Complex Nursing World*, *Journal of Nursing Administration*, 34 (6) 274-282
- Clarke, J. and Newman, J. (1997) *The Managerial State*, Sage, London.
- Clegg, Stewart (1989) *Frameworks of Power*, Sage, London.



Clegg, Stewart. (1998) *Foucault, Power and Organisations* in McKinlay A. and Starkey K. (Eds) *Foucault, Management and Organisation Theory*, Sage, London.

Clegg, S and Dunkerley, D. (1980) *Organisation, Class, Control*, Routledge and Kegan Paul, London.

Clegg, Stewart; Kornberger, Martin and Carter, Chris (2003) *The Differend, Strangers and Democracy: Theorising Polyphonic Organisation*. Conference Proceedings, Democracy in a Knowledge Economy, 2003, Briarcliff, USA

Cognitive Edge (2008) *SenseMaker Suite* (accessed 9<sup>th</sup> September 2008)  
<http://www.sensemaker-suite.com/concept.htm>

Cohen, A. (1993) *Organisational commitment and turnover: A meta-analysis*, *Academy of Management Journal*, 36 (5) 1140-1157

Cohen, A. (1974) *Two-Dimensional Man: An essay in the Anthropology of Power and Symbolism in a Complex Society*, Routledge and Kegan Paul, London.

Cohen, D. and Prusak, L. (2001) *In Good Company*, Harvard Business School Press, Cambridge, MA

Collins (2004) *English Dictionary: Complete and Unabridged*. 3<sup>rd</sup> Updated Ed. Collins, Glasgow.

Collinson, D. and Hearn, J. (1994) *Naming men as men: implications for work, organisation and management*, *Gender, Work and Organisations*, 1 (1) 2-22

Community Health Council (Wales Board) *Board of the Community Health Council in Wales* (accessed July 13<sup>th</sup> 2008).  
<http://www.nhs.uk/sites3/home.cfm?ORGID=23>

Community Health Council, Royal College of Nursing (Wales), Welsh Institute for Health and Social Care, British Medical Association (Wales), University of Wales (Swansea), The Welsh NHS Confederation (2005) *A Picture of Health: How the NHS in Wales could look in 2015*, Cardiff

Connolly, J. (2004) *Doctors and Managers: Conflicts, Professional Self Images and the Search for Legitimacy*, in Learmonth, M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers, New York

Connolly M. and Jones, N. (2003) *Constructing management Practice in the New Public Management: The case of mental health managers*, *Health Service Management Research*, 16, 203-310

Cooper, R. Frank, G.L Gouty, C.A. and Hansen, M.C. (2002) *Key ethical issues encountered in healthcare organisations: perceptions of nurse executives*, *Journal of Nursing Administration*, 32 (6) 331-337

- Corbin, J. (2008) *Is caring a lost art?* International Journal of Nursing Studies, 45 (2) 163
- Corby, S. (1997) *Opportunity 2000 in the National Health Service: A missed opportunity for women*, Journal of Management in Medicine, 11 (4-5) 279-293
- Cortazzi, M. (1993) *Narrative Analysis*, Falmer Press, London
- Costea, B; Crump, N and Amridis, K. (2008) *Managerialism, the Therapeutic Habitus and the Self*. Human Relations 61 (5) 661-685
- Cousins, M. and Hussain, A. (1984) *Michel Foucault*, MacMillan, London
- Craib, I (1992) *Modern Social Theory: From Parsons to Habermas*, 2<sup>nd</sup> Ed. Prentice Hall, Harlow
- Cullen, L. August, M. Brown, D. Ellin, H. Gill, D and Rubiner, B (2003) *I Want Your Job, Lady!* Time, 5th December, 161, (19) 52-56
- Cullum, Nicky; Ciliska, Donna; Haynes, Brian, R. and Marks, Susan (2008) *Evidenced-Based Nursing: An Introduction*, Blackwell Publishing, Oxford.
- Cunliffe, A.L. Luhman, J.T and Boje D.M. (2004) *Narrative temporality: Implications for Organisational Research*, Organisational Studies, 25 (2) 261-286
- Cunningham, R. (2000) *From great expectations to hard times? Managing equal opportunities under new public management*, Public Administration, 78 (3) 699-714
- Currie, Graeme (2006) *Reluctant but resourceful middle managers: the case of nurses in the NHS*, Journal of Nursing Management, 14 (1) 5-12
- Currie, Graeme (1997) *Management Development and a Mismatch of Objectives: The culture change process in the NHS*. Leadership and Organisational Development Journal, 18 (6) 304-311
- Currie, Graeme (1996) *Contested terrain: The incomplete closure of managerialism in the health service*, Personnel Review, 25, (5) 8-22
- Curry, B.K. (2003) *Organisational flux and its destabilising influence of employee identity*, Management Decision, 41, (6) 558-569
- Cutler, T and Waine, B (2000) *Managerialism Reformed? New Labour and Public Sector Management*, Social Policy and Administration, September, 34, (3) 318-332
- Czarniawska, B. (1998) *A Narrative Approach to Organisation Studies*, Sage, London.

## D

Dacre, John (2008) *Spheres of Medical Influence*, Clinical Medicine, 8 (1) 13-15

Dahl, R. (1958) *Critique of the ruling elite model*, American Political Science Review, 52, 463 –69

Dandeker, C. (1990) *Surveillance, Power and Modernity*, Polity Press, Cambridge

Daniels, Simon and Kydd, Angela (2007) *Should administration be reduced so nurses can have more patient contact?* Nursing Times, 2<sup>nd</sup> October 2007, 103, 40

Darwin, C. (1859) *The Origin of Species*, Reprinted 1976, Gramercy Books, New York NY

Davenport, Sally and Leitch, Shirley (2005) *Circuits of Power in Practice: Strategic Ambiguity as Delegation of Authority*, Organisation Studies, 26 (11) 1603-1623

Davidson, D.R. (1996) *The role of the nurse executive in the corporatization of healthcare*, Nursing Administration Quarterly, 20 (2) 49-53

Davies, Annette and Thomas, Robyn. (2000) *Researching Public Sector Change, The argument for a gender-inclusive framework*, Public management, 2 (4) 547-554

Davies, A. and Kirkpatrick, I. (1995) *Performance Indicator, bureaucratic control and the decline of professional autonomy: The case of academic librarians*, in Kirkpatrick, I and Lucio, M. (Eds) *The Politics of Quality: Management of Change in the UK Public Sector*, Routledge, London

Davies, C. (2002) *Managing identities: workers, professions and identity*, Nursing Management UK, September, 9 (5) 31-35

Davies, C. and Rosser, J (1986) *Gendered jobs in the health service: A problem for labour process analysis* in Wilson, M. (2002) *Making Nursing Visible? Gender, technology and the care plan as script*, Information Technology and People, 15 (2) 139-158

Davies, C. (1995) *Gender and the Professional Predicament of Nursing*, Open University Press, Buckingham.

Davies, C.A. (1999) *Reflexive Ethnography: A Guide to Researching Selves and Others*, Routledge, London.

Davis, C. (2004) *After Poststructuralism: Reading, Stories and Theory*, Routledge, Oxon.

- Davies, Huw.T.O; Mannion, Russell and Marshall, Martin N. (2001) *Treading a Third Way for Health*, Public Money and Management, April-June, 6-8
- Davies, H.T.O and Lampel J. (1998) *Trust in Performance Indicators*, International Journal of Quality and Safety in Health Care, 7, 159-162
- Davies, Pete, G. (2006) *Letter: I just wanted to be a doctor: Medicine and its representation*, British Medical Journal, 333 (7565) 446
- Deale, T. and Kennedy, A. (1982) *Corporate Cultures: The Rules and Rituals of a Corporate Life*, Penguin, London.
- Dean, Mitchell (1999) *Governmentality: Power and Rule in Modern Society*, Sage, London.
- Deetz, S. (1998) *Discursive Formations, Strategised Subordination and Self-surveillance* in McKinlay A. and Strakey, K. (Eds) Foucault, Management and Organisation Theory, Sage, London.
- Deetz, S. (1996) *Describing differences in approaches to organisation science: Rethinking Burrell and Morgan and their legacy*, Organisation Science, (7) 191-207
- Deetz, S. (1992) *Disciplinary Power in the Modern Organisation* in Alvesson, M. and Willmott, H. (Eds) Critical Management Studies, Sage, London.
- Deleuze, G. and Guattari (1988) *A Thousand Plateaus: Capitalism and Schizophrenia*, University of Minnesota Press, Minnesota
- Deleuze, G. and Guattari F. (1977) *Anti-Oedipus: Capitalism and Schizophrenia*, Viking Press, New York, NY.
- Denhardt, Robert, B. (1993) *The Pursuit of Significant Strategies for Management Success in Public Organisations*, Wadsworth, Belmont CA
- Dent, M: O'Neill, M and Bagley, C. (1999) *Professions, New Public Management and the European welfare state*, Staffordshire University Press, Stafford.
- Dent, M. and Whitehead, S. (2002) *Managing Professional Identities: Knowledge, Performativity and the 'New' Professional*, Routledge, London.
- Denzin, N. K. and Lincoln Y. (2005) *The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> Edition, Sage, London.
- Denzin, N. K. and Lincoln, Y. (2003) *The Landscape of Qualitative Research: Theories and Issues*, 2<sup>nd</sup> Ed. Sage London.
- Denzin, Norman K. (1989) *Interpretative Biography*, Sage Publications, London.

Denzin N.K. (1983) *Interpretative Interactionism*, in Morgan, Gareth (Ed) *Beyond Method: Strategies for Social Research*, Sage, Beverly Hills, CA

Department of Health (2008) *Developing the Quality and Outcomes Framework: Proposals for a new independent process*. Crown Copyright, London (accessed 10<sup>th</sup> November 2008)  
[http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_089778](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_089778)

Department of Health (2007a) *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21<sup>st</sup> Century*, The Stationery Office, London.

Department of Health, (2007b) *Safeguarding Patients: The Government's response to the recommendations of the Shipman Inquiry's fifth report and the recommendations of the Ayling, Neale and Kerr/Haslam Inquiry*, The Stationery Office, London.

Department of Health, (2006a) *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to promote the safety of patients: A report by the Chief Medical Officer*, Department of Health, London.

Department of Health (2006b) *The new GMS Contract 2006/07* (accessed October 28<sup>th</sup> 2008)  
[http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/GMS/DH\\_4125636](http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/GMS/DH_4125636)

Department of Health (2004a) *Revised terms and conditions for NHS consultants*, Department of Health, January 2004 (accessed October 13<sup>th</sup> 2008)  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4070548](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4070548)

Department of Health (2004b) *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process*, Department of Health, October 2004 (accessed October 13<sup>th</sup> 2008)  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4090843](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090843)

Department of Health (2002a) *Reforming NHS Financial Flows: Introducing Payment By Results*, Department of Health, London.

Department of Health (2002b) *Reference Costs: Collection Guidance*, NHS Executive, Leeds.

Department of Health (2001) *The NHS Plan*, The Stationery Office, London

Department of Health (1999) *Saving Lives: Our Healthier Nation (White Paper)* July 1999, Stationary Office, London.

Department of Health (1998) *A First Class Service: Quality in the New NHS*. Health Care Circular, 1998/113, Department of Health, London.

- Department of Health (1997) *The New NHS; Modern, Dependable*, The Stationery Office, London.
- Derrida, J. (1976) *Of Grammatology*, Translated by Spivak, G.C, John Hopkins University Press, London.
- Derrida, J. (1998) *Scribble (Writing-Power)* In Wolfreys, J. (Ed) *The Derrida Reader: Writing Performances*, Edinburgh University Press, Edinburgh.
- Dixon, J. Kouzmin, A. and Korac-Kakabadse, N. (1998) *Managerialism-something old, something borrowed, little new*. *International Journal of Public Sector Management*, 11 (2/3) 164-187
- Doherty, C. (forthcoming) *A qualitative study of health service reform on nurses working lives: learning from the UK*, Paper sourced directly from author (21<sup>st</sup> November 2008)
- Donaldson, Alison (2007) *Reflexive Writing and the Social Life of Documents*, 23<sup>rd</sup> EGOS Colloquium *Beyond Waltz dances of Individuals and Organisations*, University of Vienna, 5-7<sup>th</sup> July 2007
- Donaldson, L. J. (2000) *Clinical governance –a mission to improve*, *British Journal of Clinical Governance*, 5, 1-8
- Donaldson, L. J and Gray, J.A.M (1998) *Clinical Governance: A quality duty for health organisations*. *Quality in Health Care*, 7, S37-44
- Douglas, M. (1986) *How institutions think*, Routledge and Kegan Paul, London.
- Dreyfus, H.L. and Rabinow, P. (1986) *Michel Foucault: Beyond Structuralism and Hermeneutics*, Harvester Press, Brighton.
- Drucker, Peter F.(orig. 1954, 1989) *The Practice of Management*. Heinemann Professional, London.
- Drucker, Peter F. (1992) *Managing for the Future: The 1990s and Beyond*, Butterworth Heinemann, Oxford.
- Drummond, R; Evans, I; Farthing, M.J.G; Chantler, C; Cahntler, S; Riis, P (1998) *Dealing with Research Misconduct in the UK*, *British Medical Journal*, 316 1726-1733
- du Gay, P. (1996) *Consumption and Identity at Work*, Sage, London.
- Dumont Jr. (2008) *The Promise of Poststructuralism: Marginalised peoples and the Problem of Knowledge*, University of New York Press, New York, NY
- Dye, C. (2000) *Leadership in Healthcare: Values at the top*, Health Administration Press, Chicago, ILL

## E

Eagleton, T. (1983) in Davis, C. (2004) *After Poststructuralism: Reading, Stories and Theory*, Routledge, Oxon.

Eagly, A. and Johnson, B. (1990) *Gender and leadership style: a meta-analysis*, Psychological Bulletin, Volume 108, issue 2 233-256

Edge, Graeme (1969) *In the Beginning* on This is the Moody Blues, Threshold Records. London.

Edwards, N. and Mallet, C. (2007) *Managers stuck in the middle feel pressure from both sides*, Health Services Journal (6077) 17<sup>th</sup> October 2007

Edwards, N, Marshall, M. McLellan, A. and Abbasi, K (2003) *Editors Choice*, British Medical Journal, 236, 609

Egan E.A. and Surdyk, P.M. (2006) *Living professionalism: Reflections of the Practice of Medicine*, Rowman and Littlefield, Lanham, MD

Ehrensals, Patricia A.L. (2001) *Calling the Shots: How Elite Discourses Constrain Local Strategic Actors*. Proceedings of the Critical Management Studies Conference, Manchester.

Einstein, Albert (unknown) quoted in *Quote DB* (accessed October 3<sup>rd</sup> 2008) <http://www.quotedb.com/authors/albert-einstein>

Elias, N (1998) *Norbert Elias on Civilisation, Power and Knowledge: Selected Writings*, University of Chicago Press Chicago ILL

Enos and Erlbaum (1997) in Black (1997) *Rhetorics prospects; twenty five years later* in Enos T and McNabb R (Eds) *Making and Unmaking the Prospects for Rhetoric*, Lawrence Erlbaum Assoc, Mahwah, NJ

Eoyang, Glenda, H. (2001) *Conditions for Self-organising in Human Systems*, PhD Dissertation, The Union Institute and University, Cincinnati, OH

Epstein, J.M. (2007) *Generating Social Science: Studies in Agent Based Computational Models*. Princeton University Press, Princeton, NJ

Evidence-Based Medicine Working Group (1992) *Evidence-based medicine: a new approach to teach the practice of medicine*. Journal of the American Medical Association Volume 268 pp 2420-2425

Exworthy, M. and Halford, S. (1999) *Professionals and the New Managerialism in the Public Sector*, Open University Press, Buckingham.

## F

- Fairclough, N. (2003) *Analysing Discourse: Textual analysis for social research*, Routledge, Oxon.
- Falkheimer, Jesper (2007) *Anthony Giddens and Public Relations: A third way interpretation*, *Public Relations Review* 33 (3) 287-293
- Falk-Rafael, A. (1996) *Power and caring: a dialectic in nursing* *Advances in Nursing Science*, 28 (3) September, 212-223
- Feldheim, M.A. (2007) *Public Sector Downsizing and Employee Trust*, *International Journal of Public Administration*, 30 (3) 249-270
- Felluga, Dino (2003) *Modules on Foucault: On Panopticon and Carceral Society* in Felluga, D (2003) *Introductory Guide to Critical Theory* (accessed September 17<sup>th</sup> 2008)  
<http://www.cla.purdue.edu/academic/engl/theory/>
- Ferlie, E., Asbrune, L., Fitzgerald, L. and Pettigrew, A. (1996) *The New Public Management in Action*, Oxford University Press, Oxford.
- Feyerband, P. (1975) in Craib, I (1992) *Modern Social Theory: From Parsons to Habermas*, 2<sup>nd</sup> Ed. Prentice Hall, Harlow.
- Findlay, P and Newton, T. (1998) *Reframing Foucault: The Case of Performance Appraisal*, In, McKinlay A. and Starkey K. (Eds) *Foucault, Management and Organisation Theory: Introduction*, Sage London.
- Fitzpatrick, M. (2001) *The Tyranny of Health: Doctors and the regulation of lifestyle*, Routledge, London.
- Fletcher, C. (1973) *The End of Management* in Childs, J. (Ed) *Man and Organisation*, Allen and Unwin, London.
- Fletcher, J.K. (1999) *Disappearing Acts: Gender, Power and Relational Practice at Work*, MIT press, Cambridge, MA.
- Fletcher, J. (2007) *Image: changing how women nurses think about themselves: Literature Review*, *Journal of Advanced Nursing* 58 (3) 207-215
- Flynn, R (2002) *Clinical governance and governmentality*, *Health, Risk and Society*, 4 (2) July, 155-173
- Flynn, R. (1999) *Managerialism, Professionalism and Quasi-Markets* in Exworthy, M. and Halford, S (Eds) *Professionals and the New Managerialism in the Public Sector*, Open University Press, Buckingham.
- Flyvberg, B. (2001) *Making Social Science Matter: Why social inquiry fails and how it can succeed again*, Translated by Sampson, S., Cambridge University Press, Cambridge.



- Fonseca, Jose (2002) *Complexity and Innovation in Organisations: Complexity and Emergence in Organisations*, Routledge, London
- Ford, H. quoted page 11 in Lewin and Regine (1999) *The Soul at Work: Unleashing the Power of Complexity for Business Success*, Orion Business Books, London.
- Ford, J. (2004) *A feminist critique of leadership and its application in the NHS*, in Learmonth, M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers, New York.
- Forrest Gump (1994) *Memorable quotes for Forrest Gump* (accessed October 8<sup>th</sup> 2008).  
<http://www.imdb.com/title/tt0109830/quotes>
- Foss et al (1991) *Contemporary perspectives on rhetoric*, Waveland Press, Illinois, ILL
- Fricker, M. *Intuitions and Reason*, *The Philosophical Quarterly*, April, 45 (179) 181-189
- Foucault, Michel (1999) quoted in Kendall G. and Wickham, G. (1999) *Using Foucaults Methods*, Sage, London.
- Foucault, Michel (1991) *Governmentality*, in Burchill, G. Gordon, C. and Miller, P. (Ed) *The Foucault Effect*, Harvester Wheatsheaf, London.
- Foucault, M. (1988) *The ethic of care of the self as a practice of freedom* in Bernauer, J. and Rasmussen, G. (Editors) *The Final Foucault*, MIT Press, Cambridge, MA.
- Foucault. M. (1986) *The History of Sexuality: Volume III: The Care of the Self*, Reprinted 1990, Penguin, London.
- Foucault M. (1985) *The History of Sexuality, Volume II: The Use of Pleasure*, Translated by Hurley, R., Penguin, Harmondsworth.
- Foucault M (1984a) *Film and Popular Memory* in Lotringer, S. (Ed) *Foucault Live: Collected Interviews 1961- 1984*, Semiotexte, New York, NY
- Foucault, M. (1984b) *What is an Author?* in Rabinow, P. (Ed) *The Foucault Reader*, Penguin, London.
- Foucault, M. (1982) *The Subject and Power: Afterword* in Dreyfus, H.L. and Rabinow, P. (Eds) (1986) *Michel Foucault: Beyond Structuralism and Hermeneutics*, Harvester Press, Brighton.
- Foucault, M. (1980a) *Power/Knowledge: Selected Interviews and other writings, 1972-1977*, Gordon, C. (Ed) Harvester, Brighton.

- Foucault, M. (1980b) *Confessions of the Flesh*, in Gordon, C. (Ed) *Power/Knowledge: Selected Interviews and other writings, 1972-1977*, Harvester, Brighton.
- Foucault, M. (1979) *The History of Sexuality, Volume I: An Introduction*, Reprinted 1981, Pelican, Harmondsworth.
- Foucault, M. (1978) *I, Pierre Riviere: A case of Parricide in the 19<sup>th</sup> Century*, Penguin, London.
- Foucault, M. (1977) *Discipline and Punish: The birth of the prison*, Translated by Sheridan, A. Reprinted 1991, Penguin, London.
- Foucault, M. (1976) *Two Lectures*, in Gordon, C (Ed) (1980) *Michel Foucault Power/ Knowledge; Selected Interviews and other writings, 1972-1977*, Harvester Press, Brighton.
- Foucault, M. (1973) *The Birth of the Clinic: An archaeology of medical perception*, Translated by Sheridan, A.M., Tavistock, London.
- Foucault, M. (1972) *Archaeology of Knowledge*, Reprinted 2004, Routledge Classics, London.
- Foucault M. (1971) *Neitzsche, Genealogy and History* in Rabinow, P. (Ed) (1984) *The Foucault Reader*, Penguin, London.
- Foucault, M. (1967) *Madness and Civilisation: The History of Insanity in an Age of Reason*, Translated by Howard, R. Tavistock, London.
- Foucault, Michel (1966) *The Order of Things*, English edition, Reprinted 2005, Routledge Classics, Oxon.
- Fournier, V and Grey, C (2000) *At the critical moment: Conditions and prospects for critical management studies*, *Human Relations*, 53, 7-32
- Fowler, A. and Campbell, D. (2001) *Benchmarking and Performance Management in Clinical Pharmacy*, *International Journal of Operations and Production Management*, 21 (3) 327-350
- Fox, N. J. (1997) *Is There Life After Foucault? Texts, frames and differends*, in Peterson, A. and Bunton, R. (Ed) *Foucault: Health and Medicine*, Routledge, London
- Fox, A. (1994) *Beyond Contract: Work, Power and Trust Relations*, Faber and Faber, London.
- Fraser, S.W. and Greenhalgh, T. (2001) *Complexity Science: Coping with complexity: Educating for capability*. *British Medical Journal* 323, 799-802
- Friedson, E. (1994) *Professionalism reborn: Theory, Prophecy and Policy*, Polity Press, Cambridge.

Fryer, P. (2006) *What are Complex Systems: A brief description of Complex Adaptive Systems and Complexity Theory*, (accessed March 11<sup>th</sup> 2005) [www.trojanmice.com/articles/complexadaptivesystems.htm](http://www.trojanmice.com/articles/complexadaptivesystems.htm)

Fulton Y. (1997) *Nurses views on empowerment – a critical social theory perspective*, *Journal of Advanced Nursing*, 27 (2) 355 -363

## G

Gabriel , Y (2000) *Storytelling in Organisations: facts, fictions and fanstasies*, Oxford University Press, London.

Gabriel, Y. (1999) *Beyond Happy Families: A Critical Revaluation of the Control-Resistance-Identity Triangle*, *Human Relations* 52 (2) 179-199

Gardner, K and Gander, M. (1992) *Transition from clinician to administrator*, *Nursing Management*, 23 (10) 38-39

Garman, A. (2006) *Professionalism*, *Journal of Healthcare Management* 51 (4) July/August, 219-222

Garside, P. (2004) *Are we suffering from change fatigue?* *Quality and Safety in Health Care* 13 (2) 89-90

Gee, James, P. (1999) *An Introduction to Discourse Analysis: Theory and Method*, Routledge, London.

Gell-Mann, M. (1994) *The Quark and the Jaguar: Adventures of the Simple and the Complex*, Abacus, London.

Giddens, A. (1998) *The Third Way: The Renewal of Social Democracy*, Polity, Cambridge.

Giddens, A. (1984) *The Constitution of Society*, Polity, Cambridge.

Gilbert, T. (2005) *Trust and managerialism: exploring discourses of care*, *Journal of Advanced Nursing* vol 52 (4) pp454-463

Gill, J. and Johnson, P. (1991) *Research Methods for Managers*, Chapman, London.

Gleick, J. (1993) *Chaos*, Abacus, London.

Goddard, M and Mannion, R. (2006) *Decentralising the NHS: Rhetoric, Reality and Paradox*, *Journal of Health Organisation and Management*, 20 (1) 67-73

Goddard, Jean Luc (2008) *Brainy Quote* (accessed December 13<sup>th</sup> 2007) <http://www.brainyquote.com/quotes/quotes/j/jeanlucgo161264.html>

- Goffman, E. (1959) *The Presentation of Self in Everyday Life*, Doubleday, New York, NY
- Godlee, F. (2006a) *Concerns about revalidation*, British Medical Journal, 333, 965
- Godlee, F. (2006b) *While Rome Burns*, British Medical Journal, 333 (7569) 0
- Goldman, Lucien (1956) in Davis Colin (2004) *After Poststructuralism: Reading, Stories and Theory*, Routledge, Oxon.
- Goleman, Daniel (1996) *Emotional Intelligence: Why it can matter more than IQ*, Bloomsbury, London.
- Gollop, R., Whitby, E., Buchanan, D. and Ketley, D. (2004) *Influencing sceptical staff to become supporters of service improvement: A qualitative study of doctors and managers views*, Quality and Safety in Health Care, 13, 108-114
- Goodwin, B. (1994) *How the leopard changed its spots: The Evolution of Complexity*, Scribner, New York, NY
- Goodwin, C. and Harness-Goodwin, M (1997) *Contested Visions: The discursive Constitution of Rodney King* in Gunnarsson, B.L: Linell, P. and Nordberg, B. (Eds) *The Construction of Professional Discourse*, Addison-Webley Longman Ltd, Harlow
- Goodson, I.F. (1995) *The Story So far: Personal Knowledge and the Political*, in Hatch, J.A. and Wisniewski, R. (Eds) *Life History and Narrative*, Falmer Press London
- Gordon, S. (1991) in Brooks, I and MacDonald, S. (2000) *'Doing Life': Gender Relations in a Night Nursing Sub-culture*, page 222, Gender, Work and Organisation, 7 (4) October, 221-229
- Gordon, C. (1998) *Canguilhem: Life, Health and Death*, Economy and Society, 27 (2-3) 182-190
- Gore, W.L. (2008) *Gore: Our Culture* (accessed on September 25<sup>th</sup> 2007) [http://www.gore.com/en\\_xx/aboutus/culture/index.html](http://www.gore.com/en_xx/aboutus/culture/index.html)
- Gouldner, A. (1954) *Patterns of Industrialised Bureaucracy*, Colmer-Macmillan
- Graham, Linda, J. (2005) *Discourse analysis and the critical use of Foucault*, Conference proceedings, Australia Association for Research in Education, Annual Conference, Sydney
- Gramsci, Antonio (1971) *Selections from Prison Notebooks of Antonio Gramsci*, Hoare, Q. and Smith G.N. (Editors and Translators) Lawrence and Wishart, London.

- Granovetter, M. (1985) in Friedson, E. (1994) *Professionalism reborn: Theory, Prophecy and Policy*, Polity Press, Cambridge
- Greener, I (2004) *The Performance of Health Management in the NHS: A Dramaturgical Perspective*, In Learmonth, M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers, New York
- Greener, I (1999) *Shifting the Paradigm: Managerialism in the NHS*, Conference Proceedings, Critical Management Studies Conference, Manchester University, Manchester, July 1999.
- Greener, I. and Mannion, R. (2006) *Does practice based commissioning avoid the problems of fundholding?* British Medical Journal, 2nd December 2006, 333, 1168-1170
- Greener, I (2006) *Where are the medical voices raised in protest?* British Medical Journal, 333 (7569) 660- 661
- Greenhalgh, Trish (2000) *Change and Complexity*, The British Journal of General Practice, June, 514-515
- Greenwood, Davydd, J. and Levin Morten (2003) *Chapter 3: Reconstructing the Relationships between Universities and Society Through Action Research*, in Denzin, N. K. and Lincoln, Y. (2003) *The Landscape of Qualitative Research: Theories and Issues*, 2<sup>nd</sup> Ed. Sage, London.
- Greenwood, John; Pyper, Robert; Wilson, David (2002) *New Public Administration in Britain*, 3rd Ed. Routledge, London.
- Grey, Chris (2005) *A very short, fairly interesting and reasonably cheap book about studying organisations*, Sage, London.
- Grey, C. (1996) *Towards a Critique of Managerialism: The Contribution of Simone Weil*, Journal of Management Studies, 33 (5) 591-611
- Grey C. and Sinclair, A. (2006) *Writing Differently*, Organisation 13 (3) 443-453
- Griffiths, Frances (2002) *Conclusion*. In Sweeney, Keiran and Griffiths, Frances (Eds) *Complexity and Healthcare: An Introduction* Radcliffe Press, Oxford.
- Griffiths, R. (1983) *Report of the NHS Management Inquiry*, Department of Health and Social Services, London, 1983
- Grima 1991 in Chase, S (2005) *Chapter 25: Narrative Inquiry: Multiple Lenses, Approaches and Voices*, in Denzin, N. K. and Lincoln Y. (Eds) *Editors: The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> Edition, Sage, London.
- Guba, E. (1990) in Denzin, N. and Lincoln, Y (2005) *Introduction*, Denzin, N and Lincoln, Y. (Editors) *The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> Edition, Sage London.

Guba, E and Lincoln, Y (2005) *Chapter 8; Paradigmatic Controversies, contradictions and emerging confluences*, in Denzin and Lincoln 2005 (Eds) *The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> Edition, Sage London.

Gunnarsson, B.L. (1997) *On the socio-historical construction of scientific discourse*, in Gunnarsson, B.L: Linell, P. and Nordberg, B. (1997) *The Construction of Professional Discourse*, Addisson-Webley Longman Ltd, Harlow.

Gunnarsson, B.L: Linell, P. and Nordberg, B. (1997) *The Construction of Professional Discourse*, Addisson-Webley Longman Ltd, Harlow.

Guo, K. (2004) *Leadership processes for re-engineering changes to the healthcare industry*, *Journal of health, Organisation and Management*, 18, (6) 435-446

Guba, E. (1981) in Czarniawska, Barbara (1998) *A Narrative Approach to Organisation Studies*, Sage, London.

Guyen-Usly, P. (2005) *Benchmarking in Health Services*, *Benchmarking: An International Journal*, 12 (4) 293-309

## H

Habermas, J. (1990) *Moral Conscious and Communicative Action*, Translated by Lenhardt, Christian and Weber Nicholson, Shierry, Polity Press, Cambridge.

Habermas, J. (1976) *Legitimation Crisis*,. McCarthy, T. (Translator) Heinemann Education, London

Habermas, J. (1987) *The Philosophical Discourse of Modernity*, Polity Press, Cambridge.

Hackett, M.C. (1999) *Implementing clinical governance in Trusts*, *International Journal of Health Care Quality Assurance*, 12, 210-213

Hagen, Roulla and Liddle, Joyce (2007) *Changing Strategic Direction for Executive Development in the Public Sector: Opportunities for top business schools*, *International Journal of Public Sector Management* 20 (4) 325-340

Halford, S and Leonard P. (1999) *New Identities: Professionalism, Managerialism and the Construction of Self*, in Exworthy, M. and Halford, S (Eds) *Professionals and the New Managerialism in the Public Sector*, Open University Press, Buckingham.

Hall, C. (2007) *Doctors training system a 'shambles'* *Daily Telegraph*, 3<sup>rd</sup> March 2007

Hall.J. (1999) *Marginalisation Revisited*, *Advances in Nursing Science* 22 (2) 88-102

- Hallam, J (2000) *Nursing the Image: Media, Image and professional identity*, Routledge, London,
- Hallier, J. and Forbes, T. (2005) *The role of social identity in doctors' experiences of clinical managing*, *Employee Relations*, 27 (1) 47-70
- Ham, Chris and Dickinson, Helen (2008) *Engaging Doctors in Leadership*, Health Services Management Centre, University of Birmingham, Birmingham.
- Ham, C., Kipping, R., and McLeod, H. (2003) *Redesigning work processes in health care: Lessons from the National Health Service*. *The Milbank Quarterly*, 81, 415-439
- Hamilton, P. (2004) *Regeneration, rhetoric and the NHS: the case of The Vital Connection*, *International Journal of Public Sector Management*, 17 (1) 8-23
- Handy, C. (1998) *The Hungry Spirit*, Arrow, London.
- Harding, N. and Learmonth, M. (2004a) *Conclusion: Managers Do Not Do Manage* in Learmonth, M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers, New York
- Harding N. and Learmonth M. (2004b) *Thinking Critically: The Case of Health Policy Research*, *Technology Analysis and Strategic Management.*, 12 (3) 331-341
- Hardeveldt, Rob (2006) *We're not to push to wash, we are just too busy writing*, *Nursing Times*, 10<sup>th</sup> October 2006, 120, 10
- Harker, Richard, Mahar, Cheleen and Wilkes, Chris (1990) *An Introduction to the work of Pierre Bourdieu: The Practice of Theory*, MacMillan, London.
- Harley, B; Hardy, C and Alvesson, M. (2008) *Reflecting on Reflexivity: Reflexive textual practices in organisational and management theory*, *Journal of Management Studies*, 45 (3) 480-501
- Harrison, L. L. (2006) *Maintaining the ethic of caring in nursing*, *Journal of Advanced Nursing*, May, 54 (3) 25-257
- Harrison, R. and Miller, S. (1999) *The contribution of clinical directors to the strategic capability of the organisation*, *British Journal of Management* 10 (1) 23-29
- Harrison, S. (1998) *The Politics of Evidence – Based Medicine in the United Kingdom*, *Policy and Politics*, 26 (1) 15-31
- Harrison, S. Hunter, D.Marnoch, G and Pollitt, C. (1992) *Just Managing: Power and Culture in the NHS*, MacMillan, London.

Harrison, S; Hunter, D.J and Pollitt, C (1990) *The Dynamics of British Health Policy*, Unwin Hyman, London

Harrison, S and Lim, J (2003) *The frontier of control: doctors and managers in the NHS 1966 to 1997*, *Clinical Governance: An International Journal*, 8 (1)13 – 18

Harrison, S. and Pollitt, C. (1994) *Controlling Health Professionals: The future of work and organisation in the NHS*, Open University Press, Buckingham.

Harrison, S. Small, N and Baker, M. (1994) *The Wrong Kind of Chaos? The Early Years of an NHS Trust*, *Public Money and Management*, Jan-March, 39-46

Harrison, Rosemary and Miller, Susan (2002) *The Contribution of Clinical Directors to the Strategic Capability of the Organisation*, *British Journal of Management*, December, 10 (1) 23-39

Harrison, Stephen and Smith, Carole (2003) *Neo-Bureaucracy and Public Management, Competition and Change*, 7 (4) 243-254

Hassey, Alan (2002) *Chapter 4: Complexity and the Clinical Encounter* in Sweeney, Keiran and Griffiths, Frances (Eds) *Complexity and Healthcare: An Introduction*, Radcliffe Press, Oxford UK

Hastings, A. (1998) *Connecting linguistic structures and social practices: a discursive approach to social policy analysis*, *Journal of Social Policy*, 27, (2) 191-211

Hart, Edwina (2008) *Statement by the Welsh Assembly Government: NHS Reorganisation*, 30<sup>th</sup> September 2008, Welsh Assembly Government, Cardiff.

Hau, W. (2003) *Caring holistically within new managerialism*, *Nursing Inquiry*, 11 (1) 2-13

Hay, R. (1994) *A nurses' place is at the bedside*, *Nursing Standard*, 8 (27) 42-43

Haynes, P (2003) *Managing Complexity in the Public Services*, Open University Press, Buckingham.

Healthcare Commission (2008) *Press release: Most Comprehensive review of maternity services ever carried out*, 25<sup>th</sup> January 2008 (accessed 26<sup>th</sup> January 2008)

[http://2007ratings.healthcarecommission.org.uk/newsandevents/news.cfm/cit\\_id/23628/widCall1/customWidgets.content\\_view\\_1/usecache/false](http://2007ratings.healthcarecommission.org.uk/newsandevents/news.cfm/cit_id/23628/widCall1/customWidgets.content_view_1/usecache/false)

Healthcare Commission (2007) *Press Release: Health care watchdog finds significant failings in Infection control at Maidstone and Tunbridge Wells NHS Trust*, 11<sup>th</sup> October 2007 (accessed 15<sup>th</sup> October 2007)



[http://www.healthcarecommission.org.uk/yourlocalhealthservices/nhsa-zbyorganisationname.cfm?widCall1=customWidgets.content\\_view\\_1&cit\\_id=2651](http://www.healthcarecommission.org.uk/yourlocalhealthservices/nhsa-zbyorganisationname.cfm?widCall1=customWidgets.content_view_1&cit_id=2651)

Healthcare Commission (2006) *Press Release: Healthcare watchdog reveals serious failings in hospital's response to outbreaks of a potentially deadly infection*, 24<sup>th</sup> July 2006 (accessed 1<sup>st</sup> August 2006)

[http://www.healthcarecommission.org.uk/newsandevents/pressreleases.cfm?cit\\_id=41](http://www.healthcarecommission.org.uk/newsandevents/pressreleases.cfm?cit_id=41)

Hearing, S., Dent, T., Swann, J., Gunartara, I., McLellan, I., And Ikidde, U. (1999) *Maximising the contribution doctors make to NHS management*, Health Services Management Research, 12, 227-231

Hearn, J. and Parkin, W. (1987) *Sex at Work: The Power and Paradox of Organisational Sexuality*, Wheatsheaf, Brighton.

Hegney, D. (1998) *Disciplinary power and its influence on the administration and supply of medications by nurses in rural areas of Australia*, International Journal of Nursing Practice, 4 (3) 144- 150

Hehir, B. McMahon, B. Flatt, S. and Szczepanska, S (2006) *Readers panel: waste of money (reflections)*, Nursing Standard, 20 (31) 28-29

Henderson, V. (2006) *The Concept of Nursing*, Journal of Advanced Nursing, January, 53 (1) 21-31

Hertz, (1997) *Reflexivity and Voice*, Sage, Thousand Oaks, CA.

Herzberg, F. (1968) *Work and the Nature of Man*, Staples, London.

Hewison, A. (1997) *The language of management: an enduring challenge*, Journal of Nursing Management, 5,133-141

Hewison, A. (2004) *Evidence-based Management in the NHS: Is it possible?* Journal of Health Organisation and Management, 18 (5) 336-348

Hewison, A. and Griffiths, M (2004) *Leadership development in health care: a word of caution*, Journal of Health, Organisation and Management, 18 (6) 464-491

Hewison, A. and Stanton, A. (2002) *From conflict to collaboration: Contrasts and convergence in the development of nursing and management theory*, Journal of Nursing Management, 11 (1) 15-24

Hirchkop, K. and Shepherd, D. (2001) *Bakhtin and Cultural Theory*, 2<sup>nd</sup> Edition, Manchester University Press, Manchester.

Hobbs (1651) *Leviathon*, Reprinted 1914, Dent, London.

- Hoggett, P. (1996) *New Modes of Control in Public Services*, Public Administration 74 (1) 9-32
- Holland, J. (1998) *Emergence: From Chaos to Order*, Perseus Publishing, Cambridge MA
- Holland, S. (2004) *Ethics of Critique and Critique of Health Management Ethics*, in In Learmonth, M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers, New York, NY
- Holloway, J (1992) *The Media Representations of the Nurse: The implication for nursing*, in Soothill, K. Henry, C. and Kendrick, K (Eds) *Theories and perspectives in Nursing*, Chapman Hall, London.
- Holloway, W. and Jefferson, T. (2000) *Doing Qualitative Research Effectively: Free association, narrative and the interview method*, Sage, London.
- Holman-Jones, S (2005) *Autoethnography: Making the Personal Political*, in *The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> Edition, Sage, London.
- Holstein, James A. and Gubrium, Jaber, F. (2005) *Chapter 19: Interpretative Practice and Social action*, in Denzin, N. K. and Lincoln Y. (2005) *The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> Edition, Sage, London.
- Hood, Christopher (1991) *A Public Management for all Seasons*, Public Administration, 69, (Spring) 3-19
- Hopper, T. and Macintosh, N. (1998) *Management, Accounting, Numbers: Freedom or Prison, Geneen versus Foucault*, in McKinlay A. and Starkey K. (Eds) *Foucault, Management and Organisation Theory: Introduction*, Sage, London.
- Horton, S. (2003) *Editorial: Participation and involvement- the democratisation of new public management?* International Journal of Public Sector Management, 16 (6) 403-411
- Hoschild, A. (1985) in Watson, T. (2002a) *Organising and managing work: Organisational, managerial and strategic behaviour in theory and practice*, Pearson Education, Harlow.
- Hoskin, K. (1998) *Examining Accounts and Accounting for Management: Inverting Understanding of the Economic*, in Mckinlay A. and Starkey, K. (Eds) *Foucault, Management and Organisation Theory*, sage London, ISBN 08039-7547-3
- Hospurs, John (1997) *An Introduction to Philosophical Analysis*, 4<sup>th</sup> Ed. Routledge, London.
- Hothi, D. (2004) *Challenges to improve patient safety in the NHS*, Clinical Governance: An International Journal, 9, (3) 143-146

Howarth, David (2000) *Discourse Analysis*, Open University Press, Buckingham.

Huber, S. J. (2003) *The White Coat Ceremony: A contemporary medical ritual*, Journal of Medical Ethics, December, 29, (6) 364-366

Hunt, T. (2006) *I just wanted to be a doctor*, British Medical Journal, 333 (7563) 359

Hunter, David J. (2002) *Chapter 5: A tale of two tribes: The tension between managerial and professional values*, in New, Bill and Neuberger, Julia (Eds) *Hidden Assets: Values and Decision Making in the NHS*, Kings Fund, London

Hunter, D (2000) *Managing the NHS*, Healthcare UK, Kings Fund, Winter, 69-76

Hunter, F. (1953) in Clegg, Stewart (1989) *Frameworks of Power*, Sage, London.

Huntingdon, J. Gillam, S and Rosen, R (2000) *Organisational development for clinical governance*, British Medical Journal, 321, 679-682

Hurst, K (2003) *Professional self-regulation in the context of clinical governance*, International Journal of Health Care Quality Assurance, 16 (4) pp199-212

## I

Institute of Medicine (2003) *Integrity in Scientific Research: Creating an environment that promotes responsible conduct*, National Academies Press, Washington DC

IMDb Website (2008) *Memorable quotes from Apollo 13 (1995)* (accessed November 7<sup>th</sup> 2008)

<http://www.imdb.com/title/tt0112384/quotes>

Irigary, L. (1999) *The Poverty of Psychoanalysis*, In Whitford, M. (Ed) *The Irigary Reader*, Routledge, London.

Ishiguro, Kazuo (2005) *The Remains of the Day*, New Edition, Faber and Faber, London.

## J

Jackson (2000) in Stacey R. (2003) *Strategic Management and Organisational Dynamics: The Challenge of Complexity*, 4<sup>th</sup> Edition, Pearson Education, Harlow.

Jacobs, J. (1993, orig 1961) *The Death and Life of Great American Cities*, Modern Library, New York

Jary, D. (2002) *Aspects of the Audit Society*, in Dent, M. and Whitehead, S. (2002) *Managing Professional Identities: Knowledge, Performativity and the 'New' Professional*, Routledge, London

Jasper, M (2002) *Editorial: Nursing roles and nursing leadership in the new NHS- changing hats, same heads*, *Journal of Nursing Management*, 10, 63-64

Jaworski, A. and Coupland, N. (1999) *Introduction* in Jaworski, A. and Coupland, N. (Eds) *The Discourse Reader*, Routledge, London.

Jenkins, Richard (2002) *Pierre Bourdieu*, 2<sup>nd</sup> Ed, Routledge, Oxon.

Johnson, T. (1972) *Professions and Power*, MacMillan. London.

Joll, James. (1977) *Gramsci*, Fontana, London.

Jones, C.S. (2002) *Attitudes of British national Health service managers and clinicians towards the introduction of benchmarking*, *Financial Accountability and Management* 18 (2) 163-188

Jones, C.S. (2001) *Towards Benchmarking in British Acute Hospitals*, *Health Services Management Research*, 14,125-138

Jones, Michael, O. (1996) *Studying Organisational Symbolism*, Sage, London.

Joss, R. and Kogan, M. (1995) *Advancing Quality: TQM in the NHS*, Open University Press, Buckingham.

Joyce, P (1999) *Strategic management for the public services*, Open University Press, Buckingham.

Juarrero, Alicia (2002) *Dynamics in Action: Intentional behaviour as a complex system*, MIT Press, Cambridge, MA

## **K**

Kameron, D. (2007) *Research misconduct: easy to suspect, hard to prove*, *British Medical Journal*, 334, 374

Kalish, P and Kalish, B. (1987) *The changing image of the nurse*, Addison Wesley, Menlo Park, CA

Kanter, R.M. (1977) *Men and Women of the Corporation*, Basic Books, New York, NY

Kappeler, S. (1986) *The Pornography of Representation*, Polity Press, Cambridge MA

Kauffman, S. (1995) *At Home in the Universe: The Search for the Laws of Self-Organisation and Complexity*, Oxford University Press, Oxford.

- Keating, John, (1989) *Dead Poets Society*, IMDb The Internet Movie Database, (accessed November 12<sup>th</sup> 2008)  
<http://www.imdb.com/title/tt0097165/quotes>
- Kemp, P. (1993) *Beyond Next Steps: A civil service for the 21<sup>st</sup> Century*, The Social Market Foundation, London.
- Kendall G. and Wickham, G. (1999) *Using Foucaults Methods*, Sage, London.
- Kenny, M. and Florida, R. (1993) in McKinlay, A. and Taylor, P. *Through the Looking Glass: Foucault, and the Politics of Production* in, McKinlay A. and Starkey K. (Eds) *Foucault, Management and Organisation Theory: Introduction*, Sage London.
- Kerby, A. P. (1991) *Narratives and the Self*, Indiana University Press, Indiana.
- Kerfoot, K. (2002) *Leading the Leaders: The challenge of an empowered organisation*, *Nursing Economics*, 20 (3) 133-135
- Kernick, David (2002) *Chapter 6: Complexity and Healthcare Organisation*, in Sweeney, Keiran and Griffiths, Frances (Eds) *Complexity and Healthcare: An Introduction* Radcliffe Press, Oxford
- Keynes, John Maynard (1982) *The Collected Writings of John Maynard Keynes: Volume 21- Activities 1931-1939: World crisis and policies in Britain and America*, Moggridge, Donald (Ed) McMillan, London.
- Kickert, Walter, J. M. (1997) *Public Governance in the Netherlands: An Alternative to Anglo-American Managerialism*, *Public Administration*, 75 (Winter) 731-752
- Kim, H. S. (1999) *Critical reflective inquiry for knowledge development in nursing practice*, *Journal of Advanced Nursing*, 29 (5) 1025
- Kincheloe, Joe L. and McLaren, Peter. (2005) *Rethinking Critical Theory and Qualitative Research* in Denzin, N and Lincoln, Y. (Eds.), *The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> Ed. Sage, London.
- Kincheloe, Joe and McLaren, Peter (2003) *Rethinking Critical Theory and Qualitative Research* in Denzin, N and Lincoln, Y (Editors) *The Landscape of Qualitative Research: Theories and Issues*, 2<sup>nd</sup> Ed. Sage, London.
- Kirkpatrick, Ian (1999) *The Worst of Both Worlds? Public Service Without Markets or Bureaucracy*, *Public Money and Management*, October-December, 7-14
- Kirpal, S. (2004) *Work identities of nurses: Between caring and efficiency demands*, *Career Development International*, Volume 9 (3) 274-304
- Klein, R. (2007) *The Future of the Department of Health*, *British Medical Journal*, 335 2-3

- Klein, Rudolf (1995) *The New Politics of the NHS*, 3<sup>rd</sup> Edition, Longman, London.
- Klein Rudolf (1983) *The Politics of the NHS*, Longman, London
- Klint, Robert (2002) *Is the Business of Health Care Hurting the Profession*. *The Physician Executive*, May-June, 4-6
- Kmietowicz, Zosia (2008) *Fight over extended hours reaches deadlock*, *British Medical Journal*, 336, 293
- Kmietowicz, Zosia. (2006) *BMA rejects Chief medical Officer's proposals on medical regulation*, *British Medical Journal*, 333, 987
- Knights, David and Morgan, Glenn (1991) *Corporate Strategy, Organisations and Subjectivity: A Critique*, *Organisation Studies*, 12 (2) 251-273
- Knights D. and Willmott, H. (1999) *Management Lives: Power and Identity in Organisations*, Sage, London.
- Knights, D. and Vurdabakis, T (1994) *Foucault, power, resistance and all that*, in Jermier, J. Knights, D and Nord, W (Eds) *Resistance and Power in Organisations*, Routledge, London.
- Knorr-Cetina, K. (1994) in Czsarniawska, B. (1998) *A Narrative Approach to Organisation Studies*, Sage, London
- Koontz, Harold (1980) *The Management Jungle Theory Revisited*, *Academy of Management Review*, 5 (2) 175-187
- Kowalczyk, Ruth (2002) *The effect of new public management on intensive care staff*. *International Journal of Public Sector Management*, 15 (2) 118-125
- Kreitner R. and Kinicki, A. (1998) *Organisational Behaviour*, 4<sup>th</sup> Edition, Richard Irwin, New York, NY
- Kristeva, J (2003) in Denzin, N and Lincoln, Y (Eds) *Introduction: The Landscape of Qualitative Research: Theories and Issues*, 2<sup>nd</sup> Ed, Sage London.
- Kristeva, J. (1986a) *Word Dialogue and Model*, in Moi, T (Ed) *The Kristeva Reader*, Blackwell, Oxford.
- Kristeva, J. (1986b) *The System and the Speaking Subject*, in Moi, T (Ed) *The Kristeva Reader*, Blackwell, Oxford.
- Kurtz, Cynthia, F. and Snowden David, J. (2008) *Bramble Bushes in a Thicket* (accessed February 10<sup>th</sup> 2008)  
[http://www.cognitiveedge.com/ceresources/articles/52\\_Bramble\\_Bushes\\_in\\_a\\_Thicket.pdf](http://www.cognitiveedge.com/ceresources/articles/52_Bramble_Bushes_in_a_Thicket.pdf)

Kurtz, C.F and Snowden, D.J (2003) *The new dynamics of strategy: Sense-making in a complex and complicated world*, IBM Systems Journal, 42, 462-483

Kuhn, T. (1977) *The Essential Tension: Selected Studies in Scientific Tradition and Change*, University of Chicago Press, Chicago.

## L

Lacan, J. (1988) in Sarup, M. (1988) *An Introductory guide to Post-Structuralism and Postmodernism*, 2<sup>nd</sup> Ed. Pearson, Harlow.

Lacey, Penelope (2006) *Chapter 6: The experience of power, blame and responsibility in the health sector*, in Stacey, R and Griffin D (Eds) *Complexity and the Experience of Managing in Public Sector Organisations*, Routledge, Oxon.

Landrum, Nancy, E. (2000) *Doctoral Thesis: A quantitative and qualitative examination of the dynamics of Nike and Reebok storytelling as strategy*, New Mexico State University, New Mexico.

Lane, N. (2000) *The management implications of womens' employment disadvantage in a female-dominated profession: A study of NHS nursing*. Journal of Management Studies, 37 (5) 184-191

Lane, Richard, J. (2000) *Jean Beaudrillard*, Routledge, Oxon.

Langton, C.G. (1990) *Computation at the Edge of Chaos: Phase transition and emergent computation*, in Forrest, S. (Ed) *Emergent Computation*, MIT Press, Cambridge, MASS.

Lanthenas (1792) *De l'influence de la liberte sur la sante Paris 1792*, translated and quoted in Foucault. M. (1976) *The Birth of the Clinic: an archaeology of medical perception*, Tavistock, London.

Larson, M.S. (1977) *The Rise of Professionalism: A Sociological Analysis*, Berkley, University of California Press, CA

Larsson, R. and Lowendahl, B. (1996) *The Qualitative Side of Management Research*, Proceedings, Academy of Management Annual Meeting, Cinninatti OH.

Lave and Wenger (1991) *Situated Learning: Legitimate Peripheral Participation*, Cambridge University Press, Cambridge.

Law, J. and Urry, J. (2004) *Enacting the Social*, Economy and Society, 33 (3) 390-410

- Lawson, H. (1985) *Reflexivity: The Postmodern Predicament*, Hutchinson, London.
- Learmonth, M. (2006a) "Is there such a thing as 'Evidence –Based Management'?" *A Commentary on Rousseau's 2005 Presidential Address*, *Academy of Management Review* 31 (4) 1089- 1093
- Learmonth, Mark (2006b) *Guest Editorial: Tales of the Unexpected? Stirring things up in healthcare management*, *Journal of Health Organisation and Management* 19 (3) 181-189
- Learmonth, Mark (2005) *Doing things with words: The case of 'management' and 'administration'*, *Public Administration*, 83 (3) 617-637
- Learmonth, M. (2004) *Making Health Services Management Critical: A Review and a Suggestion*, In Learmonth, M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers, New York
- Learmonth, Mark and Harding, Nancy (2006) *Evidence-Based Management: The Very Idea*, *Public Administration*, 84, (2) 245-266
- Learmonth M. and Harding, N (2004) *Making Health Services Management Research Critical: A Review and a Suggestion*, in Learmonth, M. and Harding, N. (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers Inc. New York, NY
- Le Grande (2006) *Motivation, Agency and Public Policy*, Oxford University Press, Oxford.
- Levin, J.S. (2005) *Faculty in the US Community College: Corporate labour*, *Management in Education*, 19 (3) 8-11
- Levi-Strauss, C. (1966) *The Savage Mind*, University of Chicago Press, Chicago.
- Lewin, R. (1993) *Complexity: Life at the Edge of Chaos*, Phoenix, London.
- Lewin, R and Regine, B (1999) *The Soul at Work: Unleashing the Power of Complexity Science for Business Success*, Orion Business Books, London.
- Libster, Martha (2001) *Demonstrating Care: The Art of Integrative Nursing*, Delmar, Albany NY.
- Lincoln, Yvonna, S. and Guba, Egon, G. (2003) Chapter 6: *Paradigmatic Controversies, Contradictions and Emerging Confluences*, in Denzin, N. K. and Lincoln, Y. (2003) *The Landscape of Qualitative Research: Theories and Issues*, 2<sup>nd</sup> Ed, Sage London
- Lindblom, L. (2005) *The Science of Muddling Through*, *Public Administration Review*, 19, 79-88



Linstead, S. (1999) *An Introduction to the Textuality of Organisations*, Studies in Cultures, Organisations and Societies, 5, (1) 1 –10.

Lipp, Allyson (2007) Developing a Reflexive Dimension of Reflection: A framework for debate, *International Journal of Multiple Research Approaches*, 1 (1) 18-26.

Locke, J. (1694) Quoted in Hospurs, John (1997) *An Introduction to Philosophical Analysis*, 4<sup>th</sup> Ed, Routledge, London.

Longley, M. (2007) *Inaugural Professorial Lecture: The Marvellous Absurdities of the National Health Service*, University of Glamorgan, Wales, 16<sup>th</sup> October 2007

Lorenz, E. (1993) in Mitleton-Kelly, E. (2003) in *Chapter 1: Ten Principles of Complexity and Enabling Infrastructures*, In Mitleton-Kelly, E. (Ed) *Complex Systems and Evolutionary Perspectives in Organisations*, Elsevier Science Ltd, Oxford.

Loughlin, M. (2004) *Orwellian Quality: The Bosses' Revolution*, in Learmonth, M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers, New York.

Luhmann, John, T. (2005) *Narrative Processes in Organisational Discourse*, *Emergence: CO*, 7 (3/4) 15-22

Luhmann (1998) in *Chapter 5: Making in Happen: Gift, Exchange and Intimacy in Relationships*, in Bauman, Zygmunt and May, Tim (2001) *Thinking Sociologically*, 2<sup>nd</sup> Ed. Blackwell, Oxford.

Lukes, S (2005) *Power: A Radical View*, Palgrave, Ebbw Vale.

Luxon, Nancy (2004) *Truthfulness, Risk and Trust in the Late Lectures of Michel Foucault*, *Inquiry*, 49, 464-489

Lyne, J. (2001) *Contours of Intervention: How rhetoric matters to bio-medical science*, *Journal of Medical Humanities*, March, 22 (1) 3-13

Lyotard, Jean-Francois (1988) *The Differend: Phrases in Dispute*. Translated by Van Den Abbeele, G, University of Minnesota Press, Minneapolis.

Lyotard, J-F. (1984) *The Post-Modern Condition: A Report on Knowledge* (English Translation) Manchester University Press, Manchester.

## **M**

MacDonald, M. (1995) *Representing Women: Myths of femininity in the popular media*, Edward Arnold, London.

MacFarlane, A. (1994) *Statistical information about the NHS: An update*, in Cutler and Waine (2000)

- MacIntosh, R. and MacLean, D. (1999) *Conditional emergence: A dissipative structure approach to transformation*, Strategic management Journal 20 (4) 297-316
- MacIntosh, R. and MacLean, D. (2003) *Conditional emergence: Researching change and changing research*. International Journal of Operations and Production Management, 21 (9/10) 1348-1358
- MacIntyre, A. (1990) *After Virtue*, (Original 1981) Duckworth, London.
- MacLean, D. MacIntosh, R. and Grant, S (2002) *Mode 2 Management Research*, British Journal of Management, 13, 189-207
- MacKay, L. (1992) *Nursing and Doctoring: Where's the difference?* in Soothill K., Henry, C. and Kendrick, K. (Eds) *Theories and Perspectives in Nursing*, Chapman Hall, London.
- Maddock, Sue, and Morgan, Glenn (1998) *Barriers to Transformation: Beyond Bureacracy and the market conditions for collaboration in health and social care*, International Journal of Public Sector Management, 11 (4) 234-251
- Madge, T. (2006) *LetTrusts get on with it*, Nursing Standard, 21 (12) p1
- Mannion, R., Goddard, M., Kuhn, M. and Bate, R. (2005) *Decentralisation Strategies and Provider Incentives in Health Care: Evidence from the English National Health Service*, Applied Health Economics and Health Policy, 4 (1) 47-54
- Mannion, R., Goddard, M. and Smith, P. (1998) 'Assessing the Performance of NHS Trusts' in *Performance Measurement – Theory and Practice*, Centre for Business Performance, University of Cambridge.
- March (1902) *March's Thesaurus Dictionary*, Cassell and Company, London
- Marcuse, H. (1964) *One Dimension Man*, Routledge and Kegan Paul, London.
- March, J.G. and Olsen, J.P. (1976) in Streatfield, Philip, J. (2001) *The Paradox of Control in Organisations*, Routledge, Oxon
- Marcus, G.E. and Fischer, M.M.J. (1986) in Lincoln, Yvonna, S. and Guba, Egon, G. (2003) *Chapter 6: Paradigmatic Controversies, Contradictions and Emerging Confluences*, in Denzin, N. K. and Lincoln, Y. (2003) *The Landscape of Qualitative Research: Theories and Issues*, 2<sup>nd</sup> Ed, Sage London
- Mark, A. (2005) *Organising emotions in healthcare*, Journal of Healthcare Organisation and Management, 19 (4/5) 277-289
- Marquis, B.L. and Huston C.J. (2006) *Leadership roles and management functions in nursing theory and application*, Lippincott Williams, Philadelphia, PENN

Marsh, Ian; Keating, Mike; Eyre, Campbell, Rosie; McKenzie, Janet; Finnegan, Tony; McIntosh, Ian; Kilroe, Mike; Jones, Dawn; Thorogood, Nick; Green, Judith (1999) *Sociology: Making Sense of Society*, 2<sup>nd</sup> Ed. Pearson Education, Harlow.

Martin, P. and Collinson, D.L. (1999) *Gender and sexuality in organisations*, in Feree, M.M: Lorder, J. and Hess, B.B. (Eds) *Revisioning Gender*, Sage, London.

Mashto, O. (2006) *Doctors demonstrate against incoherent reforms of NHS*, British Medical Journal, 333, 989

Maslow, A.A. (1987) *Motivation and Personality* 3<sup>rd</sup> Ed, Harper Row, London

Matthews, Jean I. And Thomas Paul, T. (2007) *Managing Clinical Failure: A complex adaptive system perspective*, International Journal of Health Care Quality Assurance, 20 (3) 184-194

Matthews, Jean (2004) *Misplaced Trust: Learning from Failure in the NHS*, MBA Dissertation, Newport Business School, University of Wales.

Maturana and Varela (1980) in Stacey R. (2003a) *Strategic Management and Organisational Dynamics: The Challenge of Complexity*, 4<sup>th</sup> Edition, Pearson Education, Harlow.

May, Tim (2001) *Social Research: Issues, Methods and Processes*, 3<sup>rd</sup> Ed. Open University Press, Buckingham.

McCracken, Grant (1988) *The Long Interview*, Sage, London.

McDonald, R. (2004) *Empowerment, Modernisation and Ethics: The Shaping of Individual Identity in an English Primary Care Trust*, in Learmonth, M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers, New York, NY

McGillivray, David (2005) *Fitter, happier, more productive: Governing working through wellness*, Culture and Organisation 11 (2) 125-138

McGregor, G. (1987) *The Human Side of Enterprise*, Penguin, London.

McKinlay A. and Starkey K. (1998) *Foucault, Management and Organisation Theory: Introduction*, Sage London

McKinlay A. and Starkey K. (1998) *The Velvety Grip: Managing Managers in the Modern Organisation* in, McKinlay A. and Starkey K. (Eds) *Foucault, Management and Organisation Theory: Introduction*, sage London, ISBN 08039-7547-3

McKinlay, A. and Taylor, P (1998) *Through the Looking Glass: Foucault and the Politics of Production* in, McKinlay A. and Starkey K. (Eds) *Foucault, Management and Organisation Theory: Introduction*, Sage, London.

- McLaughlin, J. (2004) *Professional Translations of Evidence Based Medicine*, in Learmonth M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers Inc. New York, NY
- McMillan, E. (2008) *Complexity, management and the Dynamics of Change: Challenges for Practice*, Routledge, London.
- McMillan E. (2004) *Complexity, Organisations and Change*, Routledge, London.
- McNeese-Smith, D (1995) *Job satisfaction, productivity and organisational commitment*, *Journal of Nursing Administration*, 25 (9) 17-26
- McNulty, T. and Ferlie, E. (2002) *Re-engineering Health Care: the complexities of organisational transformation*, Oxford University Press, Oxford.
- McPherson K (1990) *Why do Variations Occur*, in Folmer-Anderson, T. and Mooney, G *The Challenge of Medical Practice Variations*, Macmillan, London.
- McWhinney, R. (1997) *Textbook of Family Medicine*, Oxford University Press, Oxford.
- Mead, G.H. (1934) *Mind, Self and Society*, University of Chicago Press, Chicago, ILL.
- Medd, W. (2002) *Complexity and the Social World*, *International Journal of Social Research Methodology*, 5 (1) 71-81
- Meerabeau, L. (2005) *The Invisible (Inaudible) Woman: Nursing in the English Academy*, *Gender, Work and Organisation*, Volume 12 (2) pp124-146
- Melia, K. (1987) *Learning and working: The occupational socialisation of nurses*, Tavistock, London.
- Miller, William, L. and Crabtree, Benjamin, F. (2008) *Clinical Research*, in Denzin, Norman, K. and Lincoln, Yvonna, S. (Eds) *Strategies of Qualitative Inquiry*, 3<sup>rd</sup> Edition, Sage, London.
- Miller, J.H. and Page, S.E (2007) *Complex Adaptive Systems: An Introduction to Computational Models of Social Life*, Princeton University Press, Princeton, NJ
- Miller, Gale (2006) *Chapter 13: Challenges to Social Constructionism: Alternative Perspectives on Social Problem Theory*, in Holstein, James A. and Miller Gale (Eds) *Reconsidering Social Constructionism: Debates in Social Problem Theory*, New Edition, Aldine Transactions, Edison, NJ.
- Miller, W.I. Crabtree, B.F. McDaniel, R.R. and Stange, K.C. (1998) *Understanding Change in Primary Care Practice Using Complexity Theory*, *The Journal of Family Practice*, 46, 369-376

- Miller, P. and O’Leary, T. (1987) *Accounting and the Construction of the Governable Person*, Accounting, Organisations and Society, May, 12, (3) 235-265
- Mills, C. (1956) *The Power Elite*, Quartet, Oxford.
- Mills, S. (2003) *Michel Foucault*, Routledge, Abingdon.
- Millward L and Bryan K (2005) *Clinical leadership in health care: a position statement*, Leadership in Health Services, 18 (2) xiii-xxv
- Minichiello, V; Aroni, R; Torewell, E; Alexander, L. (1995) *In-depth Interviewing: Principles, Techniques and Analysis*, 2nd Ed. Pearson Education, Sydney, AUS
- Mintzberg, Henry (1990) *Managers Jobs: Folklore or Fact*, Harvard Business Review March-April 1990, 163 – 176
- Mintzberg, Henry, Lampel, Josep, Quinn, James, B., Ghosal, Sumantra (1987) *The Strategy Process: Concepts, Contexts, Cases*, 4<sup>th</sup> Edition, Pearson Education, Harlow.
- Mintzberg, Henry (1980) *Structure in 5’s: A synthesis of research on organisational design*, Management Science, 26 (3) 322-341
- Mischler, E.G. (1997) *The Interactional Construction of narratives in medical and life history interviews*, in Gunnarson, Linnell and Nordberg, (Eds) *The Construction of Professional Discourse* Addison-Webley Longman Ltd, Harlow.
- Misztal, B. (1996) *Trust in Modern Societies*, The Free Press, New York, NY
- Misztal, B. (2002) *Trusting the Professional: A managerial discourse for uncertain times*, in Dent, P. and Whitehead, S. (2002) *Managing Professional Identities: Knowledge, Performativity and the ‘New’ Professional*, Routledge, London.
- Mitleton-Kelly, E. and Birkenkrahe, M.S. (2004a) *Treasury Operations in a Multi-national Oil Company: Dialogue on the methodology of using experiments in Complex Evolving Systems*. In *Complexity Theory and the Management of Networks*, Imperial College Press, London.
- Mitleton-Kelly, E. (2004b) *Co-evolutionary Integration: A Complexity perspective of Mergers and Acquisitions*; EGOS Conference Proceedings, Ljubljana University, Slovenia, July 2004
- Mitleton-Kelly, E. (2003a) *Ten Principles of Complexity and Enabling Infrastructures*, In Mitleton-Kelly, E. (Ed) *Complex Systems and Evolutionary Perspectives in Organisations*, Elsevier Science Ltd, Oxford.

Mitleton-Kelly, E. (2003b) *Complexity Research- Approaches and Methods: The LSE Complexity Group Integrated Methodology*, In Keskinen, A. Alltonen, M. and Mitleton-Kelly, E. *Organisational Complexity*, TUTU Publications, Finland Research Centre, Helsinki, SW.

Mitleton-Kelly, E. (1998) *Organisations as Complex Evolving Systems*, OACES Conference, Warwick, 4-5<sup>th</sup> December 1998

Morgan, G. in Gill, J. and Johnson, P. (1991) *Research Methods for Managers*, Chapman, London.

Mullins, Laurie (1999) *Management and Organisational Behaviour*, 5<sup>th</sup> Ed. Prentice Hall, Harlow.

Mumby, D.K. (1988) *Communication and Power in Organisations: Discourse, ideology and domination*. Ablex Publishing, Norwood, NJ.

Mumby, D.K and Putnam, L. (1992) *The Politics of Emotion: A Feminist Reading of Bounded Rationality*. *Academy of Management review*, 17 (3) 465-486

## N

National Assembly for Wales (2001) *Improving Health in Wales: A Plan for the NHS with its Partners*. National Assembly for Wales, Cardiff.

National Institute for Clinical Excellence (2007) *Clinical Guideline No. 50: Acutely ill patients in hospital: Recognition and response to acute illness in adults in hospital*, National Institute for Clinical Excellence, London.

Neitzsche, F. (1971) in Foucault, M. (1971) *Neitzsche, Genealogy and History* in Rabinow, P. (Ed) (1984) *The Foucault Reader*, Penguin, London.

Neitzsche, F. (1910) *The Will to Power, Book 4*, translated by Ludovici, M. cited in Robinson, Dave (1999) *Neitzsche and Postmodernism*, Page 11, Icon Books Ltd, Cambridge.

Newdick, C. (1995) *Who Should We Treat: Law, Patients and Resources in the NHS*, Clarendon Press Oxford.

Newman, J. (2003) *The New Public Management. Modernisation and Institutional Change*, in McLaughlin, K., Osbourne S. and Ferlie, E. (Eds) *New Public Management: Current trends and future prospects*, Routledge, London.

NHS Employers (2005) *Facts and Figures* (accessed 17<sup>th</sup> October 2005)  
[http://www.nhsemployers.org/Pay\\_and\\_Conditions/facts\\_and\\_figures.asp](http://www.nhsemployers.org/Pay_and_Conditions/facts_and_figures.asp)

NHS Information Service (2002) *A Brief Organisational History of the NHS*, (accessed 9<sup>th</sup> May 2005)  
<http://www.nhsia.nhs.uk/def/pages/nhsweek2002/historical.asp>

- NHS Leadership Programme (2004) *Breaking through- building a diverse leadership workforce*, NHS Leadership Centre, London, June 2004
- NHS Modernisation Agency (2004) *10 High Impact Changes for Service Improvement and Delivery: A guide for NHS leaders*. Crown Copyright, Department of Health Publications, London.
- NHS Wales (2008a) *An Introduction to NHS Wales* (accessed 1<sup>st</sup> September, 2008)  
<http://wales.nhs.uk/sites3>
- NHS Wales (2008b) *News: Minister outlines simplified NHS structure in Wales*. July 18<sup>th</sup> 2008 (accessed 1<sup>st</sup> September 2008)  
<http://www.wales.nhs.uk/newsitem.cfm?ContentID=10205>
- NHS Wales (2007) Welsh Health Circular No. 69: *An Incentives and Sanctions Framework for NHS Wales*, 26<sup>th</sup> September 2007 (accessed 20<sup>th</sup> July 2008)  
[http://www.wales.nhs.uk/documents/WHC\(2007\)069.pdf](http://www.wales.nhs.uk/documents/WHC(2007)069.pdf)
- NHS Wales (1998a) *Putting Patients First*. The Stationery Office, London (accessed 27<sup>th</sup> August 2008)  
[http://www.wales.nhs.uk/publications/whitepaper98\\_e.pdf](http://www.wales.nhs.uk/publications/whitepaper98_e.pdf)
- NHS Wales (1998b) *Better Health – Better Wales*, NHS Wales, Cardiff (accessed 27<sup>th</sup> August 2008)  
[http://www.wales.nhs.uk/publications/greenpaper98\\_e.pdf](http://www.wales.nhs.uk/publications/greenpaper98_e.pdf)
- Nicholls, S. Cullen, R. O’Neill, S. and Halligan, A. (2000) *Clinical Governance: Its origins and its foundations*. *Clinical Performance and Quality Health Care* 8 (3) 172-178
- Nicolis, G. and Prigogine, I (1989) *Exploring Complexity: An Introduction*, Freeman, W.H., New York, NY
- Nisbet, R. (1977) in Vidich, A.J. and Lyman, S.M. (2003) *Chapter 2: Qualitative methods: Their history in sociology and anthropology*, in Denzin, N. K. and Lincoln, Y. (2003) *The Landscape of Qualitative Research: Theories and Issues*, Second Edition, Sage London,
- Nobus, D. (2003) *Lacan’s science of the subject: Between linguistics and topology*, in Rabate, J-M. (Ed) *The Cambridge Companion to Lacan*, Cambridge University Press, Cambridge
- Nonaka, I. and Takeuchi, H. (1995) *The Knowledge Creating Company*, Oxford University Press, Oxford,
- Norcott, D. and Llewellyn, S. (2005) *Benchmarking in UK health: a gap between policy and practice*, *Benchmarking: An International Journal* 12 (5) 419-435

Nord, W. and Jeremiah, J. (1992) in Alvesson, M. and Deetz, S. (2000) *Doing Critical Management Research*, Sage, London.

North, Peter (2000) *The Third Way*. *Local Economy*, 14, (3) 269-273

Nursing and Midwifery Council (2004) *Code of Professional Conduct: Standards for Conduct, Performance and Ethics*. In *Mary's Reflection* 2006:6)

Nursing Times (2006) *Volume 102, Issues 27-50*, July 10<sup>th</sup> – December 12<sup>th</sup>, Macmillan, London.

Nutley, S. Perrot, S. and Wilson, F (2002) *Editorial : Gender, the Professions and Public Management*, *Public Money and Management*, January-March, 3-4

## O

Oakley, A. (1990) *Interviewing Women: A contradiction in terms*, in Roberts, H. (Ed) *Doing Feminist Research*, Routledge and Kegan Paul, London.

Oakley, A. (1981) in Fontana, A. and Frey, J.A. (2005) *Chapter 27: The Interview: From Neutral Stance to Political Involvement*, in Denzin, N. K. and Lincoln Y. (2005) *The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> Edition, Sage, London.

O'Leary, C.M. (1997) *Counter-identification or counter-hegemony? Transforming feminist standpoint theory*, in Kenny, S.J. and Kinsella, H. (Eds) *Politics and feminist Standpoint Theory*, Harworth, New York, NY.

Olesen, V.(2005) *Chapter 10: Early Millennial Feminist Qualitative Research: Challenges and Contours* in Denzin, N. K. and Lincoln Y. (2005) *The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> Edition, Sage, London

Olssen Mark (2008) *Foucault as a Complexity Theorist: Overcoming the problems of classical philosophical analysis*, *Educational Philosophy and Theory*, 40 (1) 96-117

O'Malley, P. (1996) *Risk and Responsibility*, in Rose, N (Ed) *Foucault and political reason: Liberalism, neo-liberalism and rationalities of government*, University of Chicago Press, Chicago, ILL

Ong, B.N. (1998) *Evolving perceptions of clinical management in acute hospitals in England*, *British Journal of Management*, 200 (1) 32-38

Oppenheimer (1973) in Friedson, E. (1994) *Professionalism reborn: Theory, Prophecy and Policy*, Polity Press, Cambridge.

Osborne, Stephen (2006) *Editorial: The New Public Governance*, *Public Management Review*, 8 (3) 377-387

Oseen, C. (1997) *Luce Irigaray, sexual difference and theorising leaders and leadership*, *Gender, Work and Organisation*, 4 (3) 170- 184



Owen, Jenny and Phillips, Kay (2000) *Ignorance is Not Bliss*, Journal of Management in Medicine 14 (2) 119-129

## P

Paley, John (2007) *Complex Adaptive Systems and Nursing*, Nursing Inquiry, 14 (3) September, 233-242

Palys, Ted, S. (1993) *Constructing Organisations: Methods of Research, Methods of Change* (Accessed 24th July, 2007)  
<http://www.sfu.ca/~palys/laval93.htm>

Parallada, R.J.F. (2002) *Modelling of Social Organisations: Necessity and Possibility*, Emergence: CO, 4 (1/2) 131-146

Parker, I. (1992) *Discourse Dynamics: Critical Analysis for Social and Individual Analysis*, Routledge, London.

Parker, M. (2004) *Structure, Culture and Anarchy: Ordering the NHS*, In Learmonth, M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers, New York, NY

Parker, M. (2002) *Against Management*, Polity Press, Cambridge.

Parker, P. (1994) *The Shape of Leaders to Come*: Management Today, July 1994

Parsons, Talcott (1951) *The Social System*, The Free Press, Glencoe, ILL.

Pascale, R. T. Milleman, M. and Gioja, L. (2000) *Surfing the Edge of Chaos: The Laws of Nature and the New Laws of Business*, Crown Publishers, New York, NY

Pascale, R. T. and Athos, A (1982) *The Art of Japanese Management*, Allen Lane, London

Persson, O. and Thylefors, I. (1999) *Career with no return: Roles, demands and challenges perceived by Swedish ward managers*, Nursing Administration Quarterly, 23 (3) 63-80

Peters, T and Waterman, (1982) *In Search of Excellence: Lessons from America's best run companies*, Harper Row, New York, NY

Phillips, P. (2003) *Spectator, Audience, Response* in Nelmes, J. (Ed) In *An Introduction to Film Studies*, 3<sup>rd</sup> Ed. Routledge, London.

Pierre, J. and Peters, B.G. (2000) *Governance, Politics and the State*, Macmillan, London

- Plochg, T. and Klazinga, N.K. (2005) *Talking towards excellence: A theoretical underpinning of the dialogue between doctors and managers*, *Clinical Governance: An International Journal* 10 (1) 41-48
- Plsek, P. (2001) *Redesigning healthcare with insights from the science of complexity*, In *Crossing the Quality Chasm: A new healthcare system for the 21<sup>st</sup> Century*, Appendix, National Academy Press, Washington, CO
- Plsek, P. and Greenhalgh, T. (2001) *The challenge of complexity in health care*. *British Medical Journal* 323, 625-628
- Plsek, P. and Wilson, T. (2001) *Complexity, Leadership and Management in Healthcare Organisations*, *British Medical Journal*, 323, 746-749
- Polkington, D.E. (1995) *Narrative configuration in Qualitative Analysis*, in Hatch, J.A. and Wisniewski, R. (Eds) *Life History and Narrative*, Falmer Press, London.
- Pollard, (1965) *The Genesis of Modern Management*, Penguin, Harmondsworth.
- Pollitt, C. (2000) *Is the Emperor in his Underwear? An analysis of the impacts of public management reform*, *Public Management*, 2 (2) 181-199
- Pollitt, C. (2003) *The Essential Public Manager*, Open University Press, Milton Keynes.
- Pollitt, C and Bouckart, G (2001) *Public Management Reform: A Comparative Analysis*, Oxford University Press, Oxford.
- Popolo, D. (2003) *French Philosophy, Complexity and Scientific Epistemology : Moving Beyond the Modern Episteme*, *Emergence* 5 (1) 77-98
- Potter, G. (2000) *The Philosophy of Social Science: New perspectives*, Prentice Hall, Harlow.
- Powell, G.N. (1988) *Women and Men in Management*, Newbury park CA Sage
- Power, N. (1998) *The Audit Society: Rituals of Verification*, Oxford University Press, Oxford.
- Power, N. (1994) *The Audit Explosion*, Demos, London.
- Przeworski (1980) in Lukes, S (2005) *Power: A Radical View*, Palgrave, Ebbw Vale.
- Prigogine, I. (2003) *Is Future Given*, World Scientific Publishing, London.
- Prigogine, I. (1997) *The End of Certainty: Time, Chaos and the New Laws of Nature*, Free Press, New York. NY

Prigogine, I. And Stengers, I. (1984) *Order out of Chaos: Man's New Dialogue with Nature*, Bantam Books, NY.

Pulliam, D. (2002) *Florence Nightingale: The Lady with the Lamp*, <http://womenshistory.about.com/library/prm/blladywiththelamp1.htm>

Pusey, M (1991) *Economic Rationalism in Canberra*, Sydney, Cambridge University Press, Cambridge.

## R

Rabinow, P. (1989) *French Modern: Norms and Forms of the Social Environment*, MIT Press, Cambridge, MA.

Raine, R. (1998) *Evidence-based Policy: Rhetoric and Reality*, Journal of Health Service Research Policy, 3 (4) 251-3

Rainey, H (1997) *Understanding and Managing Public Organisations*, 2<sup>nd</sup> Edition, Josey-Bass SF.

Ranson, S. and Stewart, J. (1994) *Management in the Public Domain: Enabling the Learning Society*, McMillan, Basingstoke.

Reed, M. (1989) *The Sociology of Management*, Harvester Wheatsheaf, Hemel Hempstead.

Regine, B and Lewin, R. (2000) *Leading at the Edge: How leaders influence complex systems*. Emergence: A Journal of Complexity Issues in Organisations and Management 2 (2) 5-23

Reissman, Catherine, K. (1993) *Narrative Analysis*, Sage, London.

Rhodes, M. and Mackechnie, G. (2003) *Understanding Public Service Systems: Is there a role for Complex adaptive Systems Theory*, Emergence: CO, 5 (4) 57-85

Rhodes, R.A.W. (1997) *Understanding Governance: Policy Networks, Governance, Reflexivity and Accountability*, Open University Press, Buckingham.

Richardson, K. (2005) *The hegemony of the physical sciences: an exploration in complexity thinking*, Futures, 29<sup>th</sup> January, 37, 615-653

Richardson, Kurt; Cilliers, Paul and Lissack, Michael (2007) Chapter 2: *Complexity science: A 'Gray' Science for the 'Stuff' in Between*, in Cilliers, Paul (Ed) Thinking Complexity: Complexity and Philosophy Volume I, ISCE Publishing, Mansfield.

- Richardson, L and St. Pierre, E (2005) *Chapter 38; Writing: a Method of Inquiry*, in Denzin and Lincoln (2005) *The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> Edition, Sage, London.
- Richman, J and Mercer, D. (2004) *'Modern language' or 'spin'? Nursing, 'newspeak' and organisational culture*, *Journal of Nursing Management*, 12 (5) 290- 298
- Ricoeur, P. (1981) in Czarsniawska, B. (1998) *A Narrative Approach to Organisation Studies*, Sage, London.
- Riggins, S. H. (1997) *The Rhetoric of Othering*, in Riggins, S.H. (Ed) *The Language and Politics of Exclusion*, Sage, London.
- Ripley, Robert E. and Ripley, Marie, J. (1992) *Empowerment, the cornerstone of quality*, *Management and Decision*, 30 (4)
- Robinson, B. (2001) *Victorian Medicine: From Fluke to Theory*  
[http://www.bbc.co.uk/history/discovery/medicine/Victorian\\_medicine\\_06\\_shtml](http://www.bbc.co.uk/history/discovery/medicine/Victorian_medicine_06_shtml)
- Roberts, I; Smith, R. and Evans, R. (2007) *Doubts over studies on mannitol in head injury*, *British Medical Journal*, 334, 392-394
- Roberts S. (2000) *Development of a positive identity: liberating oneself from oppressor myths*, *Advances in Nursing Science*, June, 22 (4) 71-82
- Rock, P. (1979) *The Making of Symbolic Interactionism*, Macmillan, Basingstoke.
- Rogers, W.A. (2002) *Is there a tension between Doctors' Duty of Care and Evidence-Based medicine?* *Health Care Analysis*, 10, 277-287
- Rorty, R (1980) *Philosophy and the mirror of nature*, Basil Blackwell, Oxford.
- Rose, N. (1999a) *Powers of Freedom: Reframing Political Thought*, Cambridge University Press, Cambridge.
- Rose, N. (1999b) *Governing the Soul: The Shaping of the Private Self*, 2<sup>nd</sup> Edition, Free Association Books, London.
- Rosenthal, M.M. (2002) *Medical professional autonomy in and era of accountability and regulation*, in Dent, M. and Whitehead, S. (2002) *Managing Professional Identities: Knowledge, Performativity and the 'New' Professional*, Routledge, London.
- Rousseau, D.M. (2006a) *Is there such a thing as "Evidence- Based Management"?* *Academy of Management Review* 31 pp 256-269
- Rousseau, D.M. (2006b) *Keeping an Open Mind About Evidence-Based Management: A Reply to Learmonth's Commentary*. *Academy of Management Review*, 31 (4) pp1091-1093

Roussel, Linda, Swansburg, Russell, C. and Swansburg, Richard J., (2008) *Management and Leadership for Nurse Administrators*, 4<sup>th</sup> Ed. Jones and Bartlett, Sudbury, MA.

Rowlinson, Michael; Toms, Steven and Wilson, John F. (2007) *Competing Perspectives on Managerial Revolution: From 'Managerialist' to 'Anti-Managerialist'*, *Business History*, 49 (4) 464-482

Royal College of Nursing, (2005a) *RCN Employment Survey 2005* (accessed July 25<sup>th</sup> 2007)  
<http://www.rcn.org.uk>

Royal College of Nursing (2005b) *Too Posh To Wash*, Conference proceedings, May 2004, Harrogate.

Royal College of Physicians (2008) *Doctors in Society: Medical professionalism in a Changing World: Main Report*, (accessed 20<sup>th</sup> May 2008).  
<http://www.rcplondon.ac.uk/pubs/books/docinsoc/docinsoc.pdf>

## S

Sackett, D. Rosenberg, J Muir-Gray, (1996) *Evidence-based medicine; What it is and what it isn't*, *British Medical Journal*, 312, 71-72

Salvage, J. (1985) *The Politics of Nursing*, Heinemann, London.

Salvage, J. (2001) *Reputations: Florence Nightingale*, *British Medical Journal*, 323, 72

Salvage, J. (2006) *More than a makeover is needed to improve nursing's image*, *Journal of Advanced Nursing*, May, 54 (3) 259-260

Samanta, A. and Samanta, J. (2004) *NICE Guidelines: Clinical Governance implications for Trusts*, *Clinical Governance: An International Journal*, 9 (4) 212-215

Sambrook, Sally (2006) *Management Development in the NHS: nurses and managers, discourses and identities*, *Journal of European Industrial Training*, 30 (1) 48-64

Sanders, J. (2007) *Recent developments in patient safety in primary care*, *Quality in Primary Care*, 15 (3) 165-167

Sanders, Irene,T. (1998) *Strategic Thinking in the New Science: Planning in the Midst of Chaos, Complexity and Change*, The Free Press, New York, NY

Santosus, M. (1998) *Simple, Yet Complex*, *Business Management*, April 15<sup>th</sup> (accessed May 12<sup>th</sup> 2005)

[http://www.cio.com/archive/enterprise/041598\\_qanda.html](http://www.cio.com/archive/enterprise/041598_qanda.html)

Sarra, N. (2006) *The emotional experience of performance management in the health sector*, In Stacey, R. and Griffin D. (ed) *Complexity and the Experience of Managing Public Sector Organisations*, Routledge, London.

Sarup, Madan (1988) *An Introductory guide to Post-Structuralism and Postmodernism* 2<sup>nd</sup> Ed. Pearson, Harlow.

Saunders, M. Lewis, P. and Thornhill, A. (2007) *Research Methods for Business Students*, 4<sup>th</sup> Ed. Pearson Education, Harlow.

Savage, M. (1998) *Discipline, Surveillance and the Career- Employment of the Great Western Railway 1833-1914*, in, McKinlay A. and Starkey K. (1998) *Foucault, Management and Organisation Theory*, Sage, London.

Schein, E.H. (1984) *Coming to a new awareness of organisational culture*, Sloan Management Review, Winter, 3-16

Scheurich, J.J. and McKenzie, K.B (2005) *Chapter 33: Foucault's Methodologies*, in Denzin, N. K. and Lincoln Y. (Eds) *The Sage handbook of Qualitative Research*, 3<sup>rd</sup> Ed. Sage, London

Schwandt, T.A. (1996) *Three Epistemological Stances for Qualitative Inquiry*, in Denzin, N.K. and Lincoln, Y.S. (Eds) *The Landscape of Qualitative Research: Theories and Issues*, 2003, 2<sup>nd</sup> Ed, Sage, London.

Schwartz, Barry (1986) *The Battle for Human Nature: Science, Morality and Modern Life*, Penguin, Ontario, CA.

Scott , John (2001) *Power*, Polity Press, Cambridge.

Seddon, J. (2005) *Freedom from Command and Control: A better way to make the work work*, 2<sup>nd</sup> Ed. Vanguard, Buckingham.

Sehested, K. (2002) *How Public Management Reforms Challenge the Roles of Professionals*, *International Journal of Public Administration* 25 (12) pp1513-1533

Semler, R. (2003) *The Seven-Day Weekend: A better Way to Work in the 21<sup>st</sup> Century*, Century, London.

Semler, R. (1993) *Maverick!* Century, London.

Senge, Peter (1990) *The Fifth Discipline: The art and practice of the learning organisation*, Century Business, London.

Sennett, R. (1998) *The Corrosion of Character: The personal consequences of work in the new capitalism*, W.W. Norton, New York, NY

Shaw Eynon (2009) *Submarine* (unreleased)

<http://www.myspace.com/eynonshaw>

Shaw, P. (2002) *Changing conversations in organisations: a complexity approach*, Routledge, London.

Sheckelle, P.G. Wolfe, S.H. Eccles, M. and Grimshaw, J (1999) *Clinical Guidelines: Developing Guidelines*, British Medical Journal, 318, 593-596

Shepherd, C and Cassell, C. (2006) *A rhetorical analysis of 'paradigm wars'*, British Academy of Management Conference, September 12-13<sup>th</sup> 2006, Belfast.

Sherrod, B. Sherrod, D and Rasch, R. (2005) *Men at Work*, Nursing Management, October, 36, (10) 46-51

Short, S. Sharman, E. and Speedy, S. (1993) *Sociology for Nurses: An Australian Perspective*, MacMillan Education Australia, Victoria.

Silvetti, C. (1990) *Nursework: From the eyes of a nurse manager*, In Gasparis L. and Swirsky, J. (Ed) *Nurse abuse impact and resolution*, Power, New York.

Simon, H. (2000) in Pollitt, C. (2003) *The Essential Public Manager*, Open University Press, Milton Keynes.

Simon, J. (1995) *Foucault and the Political*, Routledge, London.

Skalen, Per (2004) *NPM Reform and the Construction of Organisational Identities*, International Journal of Public Sector Management, 17 (3) 251-263

Skoldberg, K (1994) *Tales of change: Public Administration reform and narrative modes*, Organisation Science, 5, 219-238

Small, N. and Mannion, R. (2004) *Critical Health Economics*, in Learmonth M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers Inc., New York, NY

Smircich, Linda (1983) *Concepts of culture and organisational analysis*, Administrative Science Quarterly, 28, 339- 358

Smith, L.T. (2005) *On Tricky Ground: Researching the Native in the Age of Uncertainty* in Denzin and Lincoln (2005) Editors: *The Sage handbook of Qualitative Research*, 3<sup>rd</sup> Edition, Sage, London

Smith, M. (1999a) *The Emergency Department as a Complex System*, Unpublished draft,  
<http://necsi.org/projects/yaneer/emergencydeptcx.pdf>

Smith, Rebecca (2008) *Alan Johnson and BMA clash over hours*, Daily Telegraph, February 4<sup>th</sup> 2008

Smith, R. (2003) *What doctors and managers can learn from each other*, British Medical Journal, 326, 610-611

- Smy, J. (2005) *Nursing through the Century*, Nursing Times, October, 10 (41) 11-18
- Snowden, David J. and Boone, Mary E. (2007) *A Leaders Framework for Decision Making*, Harvard Business Review, November, 83, 68-76
- Sokal and Bricomont (1977) in Davis C. (2004) *After Post Structuralism: Reading, Stories and Theory*, Routledge, Oxon.
- Som, C.V. (2005) *Nothing seems to have changed, nothing seems to be changing and perhaps nothing will change in the NHS: Doctors response to clinical governance*, International Journal of Public Sector Managemtn 18 (5) 463-477
- Sotirin, P and Tyrell, M (1998) *Wondering about Critical Management Studies*, Management Communication Quarterly, 12 (2) 303-336
- Spretnak, Charlene, (1991) *States of Grace: The recovery of meaning in a postmodern age*, Harper Collins, New York, NY
- Stacey, R. (2003a) *Strategic Management and Organisational Dynamics: The Challenge of Complexity*, 4<sup>th</sup> Edition, Pearson Education, Harlow.
- Stacey, R. (2003b) *Complexity and Group Processes: A radically social understanding of individuals*, Routledge, London.
- Stacey, R and Griffin D (Editors) (2006) *Complexity and the Experience of Managing in Public Sector Organisations*, Routledge, Oxon.
- Stark, S., Stronach, I. and Warne, T. (2002) *Teamwork in Mental Health: rhetoric or realit*, Journal of Psychiatric and Mental Health Nursing. 9 (4) 411-418
- Stein, G. (1960) in Denzin, Norman K. (1989) *Interpretative Biography*, Sage Publications, London.
- Stern, D.T (Ed) (2006) *Measuring medical Professionalism: Understanding doctors performance*, Open University Press, Milton Keynes.
- Strasen, L.L. (1992) *The image of professional nursing: Strategies for action*, Lippincott, Philadelphia, PEN.
- Strauss, A. (1963) *The Hospital in Modern Society*, MacMillan, New York, NY
- Streatfield, Philip, J. (2001) *The Paradox of Control in Organisations*, Routledge, Oxon.
- Street, A. (1992) *Inside Nursing: A critical ethnography of clinical nursing practice*, State University of New York, Albany, NY



Stubbs, M. (1983) *Discourse Analysis*, University of Chicago Press, Chicago ILL

Styhre, A. (2004) *Messy texts and Conceptual Activism in Organisational Theory*, Conference Proceedings, Academy of Management Conference, St Andrews University, September 2004, St Andrews, Scotland.

Sutherland, K. and Dawson, S (1998) *Power and quality improvement in the new NHS: the roles of doctor and managers*, *Quality in Health Care*, 7 S16-S23

Sweeney, Keiran and Cassidy Paul, (2002) *Chapter 7: Clinical Governance and Complexity*, in Sweeney, Keiran and Griffiths, Frances (Eds) *Complexity and Healthcare: An Introduction*, Radcliffe Press, Oxford.

Swage, T. (2000) *Clinical Governance in Health Care Practice*, Butterworth-Heinemann, Oxford.

## T

Taylor, M. (2001) *The Moment of Complexity: Emerging Network Culture*, University of Chicago Press, Chicago, IL

Taylor, S.J. and Bogdan, R. (1984) *Introduction to Qualitative Research Methods*, 2<sup>nd</sup> Ed. Wiley, New York, NY

Teale, M., Dispenza, V., Flynn, J. and Currie, D. (2003) *Management Decision-Making: Towards an integrative approach*, Prentice Hall, Harlow.

Thomas, D. (2007) *The Managerialistic Ideology of Organisational Change Management*. *Journal of Public Management* 20 (1) 126-144

Thomas, P. Liddle, J and Matthews, J. (forthcoming 2009) *Managerialism: A prescription for Health: Rethinking the enhanced role of the professional manager in the public sector*, *International Journal of Public Sector Management*

Thomas, P. and Matthews, J. (2006) *Managerialism: A prescription for Health: Rethinking the enhanced role of the professional manager in the public sector*, Conference Proceedings, British Academy of Management Conference, Belfast, September 11-13<sup>th</sup> 2006

Thomassen, L. (2006) (Ed) *The Derrida-Habermas Reader*, Edinburgh University Press, Edinburgh.

Thompson, J. (1987) *Critical Scholarship- The Critique of Domination in Nursing*, *Advances in Nursing Science*, 10 (1) 27-38

Thorne, M.L. (1997) *Myth-management in the NHS*, *Journal of Management in Medicine*, 11 (3) 168-180

Timmins, N (2007) *What's next for the NHS*, British Medical Journal, 335, 18-19

Tooke, J. (2008) *Aspiring to Excellence: Findings and final recommendations of the Independent Inquiry into Modernising Medical Careers* (accessed September 4<sup>th</sup> 2008)

[http://www.mmcinquiry.org.uk/MMC\\_FINAL\\_REPORT\\_REVD\\_4jan.pdf](http://www.mmcinquiry.org.uk/MMC_FINAL_REPORT_REVD_4jan.pdf)

Tuhiwai-Smith, L (2005) *On Tricky Ground: Researching the Native in the Age of Uncertainty*, in Denzin and Lincoln, (2005) *The Sage Handbook of Qualitative Research*, 3rd Edition, Sage, London.

Traynor, M. (2004) *Nursing, Managerialism and Evidence Based Practice: The Constant Struggle for Influence*, in Learmonth, M. and Harding, N (Eds) *Unmasking Health Management: A Critical Text*, Nova Science Publishers, New York, NY

Turner, Barry (1990) *The Rise and Fall of Organisational Symbolism*, in Hassard, J. and Pym, D. (Eds) *The Theory and Philosophy of Organisations: Critical issues and New Perspectives*, Routledge, London.

Turner, B.S. (1997) *From governmentality to risk: some reflections on Foucault's contribution to medical sociology*, In Peterson, A. and Bunton, R. (Eds) *Foucault, Health and Medicine*, Routledge, London.

## V

Van Maanen, J. (1988) *Tales of the Field: On writing ethnography*, Chicago Uni Press, Chicago. ILL

Van Maanen, J. Manning, P.K. and Miller, M.L. (1998) in *Introduction*, Czarniawska, B. (1998) *A Narrative Approach to Organisational Studies*, Sage, London.

Varcoe, C. (1996) *Theorising oppression: Implications for nursing research on violence*. *The Canadian Journal of Nursing Research* 28 (11) 61-78

Venables M. and Bilge, U. (1998) *Complex Adaptive Modelling at J Sainsbury: The SimStore Supermarket Supply Chain Experiment*, Strategy & Complexity Seminar, London School of Economics, 30 March, (accessed May 21<sup>st</sup> 2008)  
<http://www.lse.ac.uk/lse/complex>

Vickers, Margaret, H. and Kouzmin, Alexander (2001) *'Resilience' in Organisational Actors and rearticulating voice*, *Public Management Review* 3 (1) 95-119

Vidich, A and Lyman, S (2003) *Qualitative Methods: Their history in Sociology and Anthropology*, In Denzin, N. and Lincoln, Y. (Eds) *The Landscape of Qualitative Research: Theories and Issues*, 2<sup>nd</sup> Ed. Sage, London.

Viitanen, E. Lehto, J. Tampsi-Jarvala, T. Mattila, K. Virjo, I. Isokoski, M. Hyppola, H. Kumpusalo, E. Halila, H. Kujala, S. and Vanska, J. (2006) *Doctors-manager as decision-makers in hospitals and health centres*, Journal of Health Organisation and Management, 20 (2) 85-94

## W

Wagner, L. (1993) *Women's voice: the case of nursing information systems*, AI and Society, 7, 295-310

Waite, S. and Nolte, E. (2005) *Benchmarking health systems; Trends, conceptual issues and future perspectives*, Benchmarking: An International Journal, 12 (5) 436-448

Waldrop, M.M. (1994) *Complexity*, Penguin, New York, NY

Wallerstein, I (1996) *Open the Social Sciences*. Report of the Gulbenkian Commission, , Stanford University Press, Stanford, CA

Walshe, K (2000) *Clinical Governance: A Review of the Evidence*, In Som, C.V. (2005) Nothing seems to have changed, nothing seems to be changing and perhaps nothing will change in the NHS: Doctors response to clinical governance, International Journal of Public Sector Management, 18 (5) 463-477

Walshe, Keiran (2003) *Regulatory Healthcare: A prescription for improvement*, Open University Press, Buckingham.

Walshe, K. and Benson, L. (2005) *Time for radical reform: GMC and the future of revalidation*, British Medical Journal, 330 (7506) 1504-1506

Wanless, Derek (2002) *Securing Our Future Health: Taking a Long Term View*. HM Treasury, London.

Waters, Adele (2008) *Mind your differentials*, Nursing Standard 8 January 2008 22 (18) 18-21

Waters, A. (2005) *Nursing is the most emotionally rewarding career*, Nursing Standard, April, 19 (30) 22-28

Watson, J (2006) *Can and ethic of caring be maintained?* Journal of Advanced Nursing 54 (3) May, 257-259

Watson, T. (2002a) *Organising and managing work: Organisational, managerial and strategic behaviour in theory and practice*, Pearson Education, Harlow.

Watson, T (2002b) *Speaking Professionally*, in Dent, M. and Whitehead, S. (2002) *Managing Professional Identities: Knowledge, Performativity and the 'New' Professional*, Routledge, London.

- Watts, D.J. (2004) *The "New" Science of Networks*, Annual Review of Sociology, 30 243-270
- Watts, D.J. and Strogatz, S.H. (1998) *Collective dynamics of small-world networks*, Nature, 393, 409-410
- Wear, D. and Aultman, D.M. (2006) *Professionalism in Medicine*, Springer Verlag, New York, NY
- Weaver, Warren (1948) *Science and Complexity*, Reprinted Emergence: CO, 6 (3) 65-74
- Webster, C. (2002) *The NHS: A Political History*, Second Edition, Oxford University Press, Oxford.
- Wells, J.S.G. (1998) *The growth of managerialism and its impact on nursing in the NHS*, in Norman, Ian and Cowley, Sarah (Eds) *The Changing Nature of Nursing in a Managerial Age*, Blackwell Science, Oxford.
- Welsh Assembly Government (2008) *Proposal to change to structure of the NHS in Wales*, April 2008, Welsh Assembly Government, Cardiff.
- Welsh Assembly Government (2007a) *One Wales: A progressive agenda for the government of Wales*, Welsh Assembly Government, June 2007
- Welsh Assembly Government, (2007b) *Welsh Health Circular (2007) 023: NHS Commissioning Guidance*. Welsh Assembly Government, Cardiff.
- Welsh Assembly Government (2006a) *Government of Wales Act*. <http://www.opsi.gov.uk>
- Welsh Assembly Government (2006c) *Designed to Work: A workforce strategy to deliver Designed for Life*. Welsh assembly Government, July 2006, Cardiff.
- Welsh Assembly Government (2006d) *The National Service Framework for Older People in Wales*, Welsh Assembly Government, Cardiff  
<http://www.wales.nhs.uk/sites3/documents/439/NSFforOlderPeopleInWalesEnglish.pdf>
- Welsh Assembly Government (2005) *Designed for Life: Creating world-class health and social care for Wales in the 21<sup>st</sup> Century* (May 2005) Welsh Assembly Government, Cardiff.
- Welsh Assembly Government (2004) *Making the Connections: Delivering Better Services for Wales*, Welsh Assembly Government, Cardiff.
- Welsh Assembly Government (2003) *Fundamentals of Care: Guidance for Health and Social Care Staff: Improving the quality of the fundamentals aspects of health and social care for adults*, Welsh Assembly Government Cardiff.  
<http://www.wales.nhs.uk/documents/booklet-e.pdf>

- Welsh Assembly Government (2002) *The Health and Social Care Guide for Wales*, Crown Copyright, Cardiff.
- Wengraff, Tom (2001) *Qualitative Research Interviewing*, Sage, London.
- West, C. and Zimmerman, D.H. (1991) *Doing gender*, In Lorber, J. Farrell, S.A. (Eds.) *The Social Construction of Gender*, Sage, London.
- Westmoreland, D. (1993) *Nurse managers perspectives of their work: Connection and relationship*, *Journal of Nursing Administration*, 23, (1) 60-64
- Wetherall, M., Yates, S. and Taylor, S. (2001) *Discourse Theory and Practice: A Reader*, Sage, London.
- Wheeler, H. (1998) *Nurse Occupational Stress: Sources and determinants of stress*, *British Journal of Nursing*, 7 (1) 40-43
- Whetton D.A. and Godfrey, P.C. (1998) *Identity in Organisations: Building theory through conversations*, Sage, Thousand Oaks, CA.
- White, R. (1986) *From matron to manager: The political construction of reality* in White, R. (Ed) *Political issues in Nursing: Past, Present and Future*, Volume 2 John Wiley, New York, NY
- Whitehead, S., Moodley, R. and Thomas P. (forthcoming) *Gender and Identity: Introduction and New Directions*, Polity Press, Cambridge.
- Whitfield, L. (2000) *A bit under the weather*, *Health Services Journal*, 110 (5712) 8-19
- Whyte, W.H. (1961) *The Organisation Man*, Penguin, Harmondsworth.
- Williams, C. Soothill, K and Barry, J. (1992) *Nursing wastage from the nurses perspectives*, in Soothill, Henry, C. and Kendrick, K (Eds) *Theories and Perspectives in Nursing*, Chapman Hall, London.
- Williams, G. (1999) *French Discourse Analysis: The method of post-structuralism*, Routledge, London.
- Willmott, Hugh (1993) *Strength is ignorance, slavery is freedom: managing culture in modern organisation*, *Journal of Management Studies*, 30 (5) 515-552
- Willmott, H.C. (1987) *Studying Managerial Work: A Critique and a Proposal*, *Journal of management studies*, 24 (3) 249-270
- Wilson, T.; Holt, T. and Greenhalgh, T. (2001) *Complexity Science: Complexity and Clinical Care*, *British Medical Journal*, 323, 685-688.
- Wilson, M. (2002) *Making Nursing Visible? Gender, technology and the care plan as script*, *Information Technology and People*, 15, (2) pp139-158

Winyard, G. (2003) *Doctors, managers and politicians, clinical medicine*, Journal of the Royal College of Physicians 3 (5) 465-469

Wodak, R. (1997) *Critical Discourse Analysis and the study of the doctor-patient interaction* in Gunnarsson, B.L. Linell, P. and Nordberg, B. (Eds) *The Construction of Professional Discourse*, Addison-Webley Longman Ltd, Harlow

Wolff, R. (2008) *The Philosopher's Zone: Doing without a ruler: In defence of anarchism*. ABC National Radio 3rd May 2008 (accessed 8<sup>th</sup> May 2008)  
<http://www.abc.net.au/rn/philosopherszone/stories/2008/2229189.htm#transcript>

Wolfram quoted in Waldrop, M.M. (1994) *Complexity: The Emerging Science at the Edge of Chaos*, Viking, London.

Wolfram-Cox J.R. Mann, L. and Samson, D. (1997) *Benchmarking as a mixed metaphor: disentangling assumptions of competition and collaboration*, Journal for Management Studies, 34 (2) 283-314

Wood, Nancy .F. (2000) *Crisis in nursing has its roots in an image problem*. Seattle Post-Intelligencer, September 3<sup>rd</sup> 2000 (accessed May 3<sup>rd</sup> 2005)  
<http://seattlepi.nwsourc.com/opinion/focus01.shtml>

World Health Organization (1946) *Preamble to the Constitution*, International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, page 100 Entered into force on 7 April 1948.

Worthington, F. (2004) *Management Change and Culture in the NHS: rhetoric or reality*, *Clinician in Management*, 12 (2) 55-67

Wright, S. (2004) *The value of value*, *Nursing Standard* 19 (9) 15-16

Wright, Elizabeth and Wright, Edmund (1999) *The Zizek Reader*, Blackwell, Oxford.

## Y

Yancy, G. (2002) *Challenging the white male philosophical voice*, *Journal of Social Philosophy*, 33 (4) 563-580

Young, A. (2000) *"I'm just me": A study of managerial resistance*, *Journal of Organisational Change*, 13, (4) 375-388

Young, A. (1999) *Rule breaking and new opportunistic managerialism*, *Management Decision*, 37, (7) 582-588

Young, C and Godlee, F. (2007) *Managing suspected research misconduct*, *British Medical Journal*, 334, 378-379

## Z

Zerubavel, E. (1979) in Richman, J and Mercer, D. (2004) *'Modern language' or 'spin'?* *Nursing, 'newspeak' and organisational culture*, *Journal of Nursing Management* 12 (5) 290- 298

Zimmerman, B., Lindberg, C. and Plsek, P. (1998) *Edgework: Insights from complexity science for health care leaders*, VHA, Irving TX

Zipin, L and Brennan, M. (2003) *The suppression of ethical dispositions through managerial governmentality: A habitus crisis in Australian higher education*, *International Journal of Leadership in Education*, 6 (4) 351-370

## **APPENDICES**

**Appendix I:** The Literature Review Pathway

**Appendix II:** The Letter of Approach

**Appendix III:** The Participant Information Leaflet

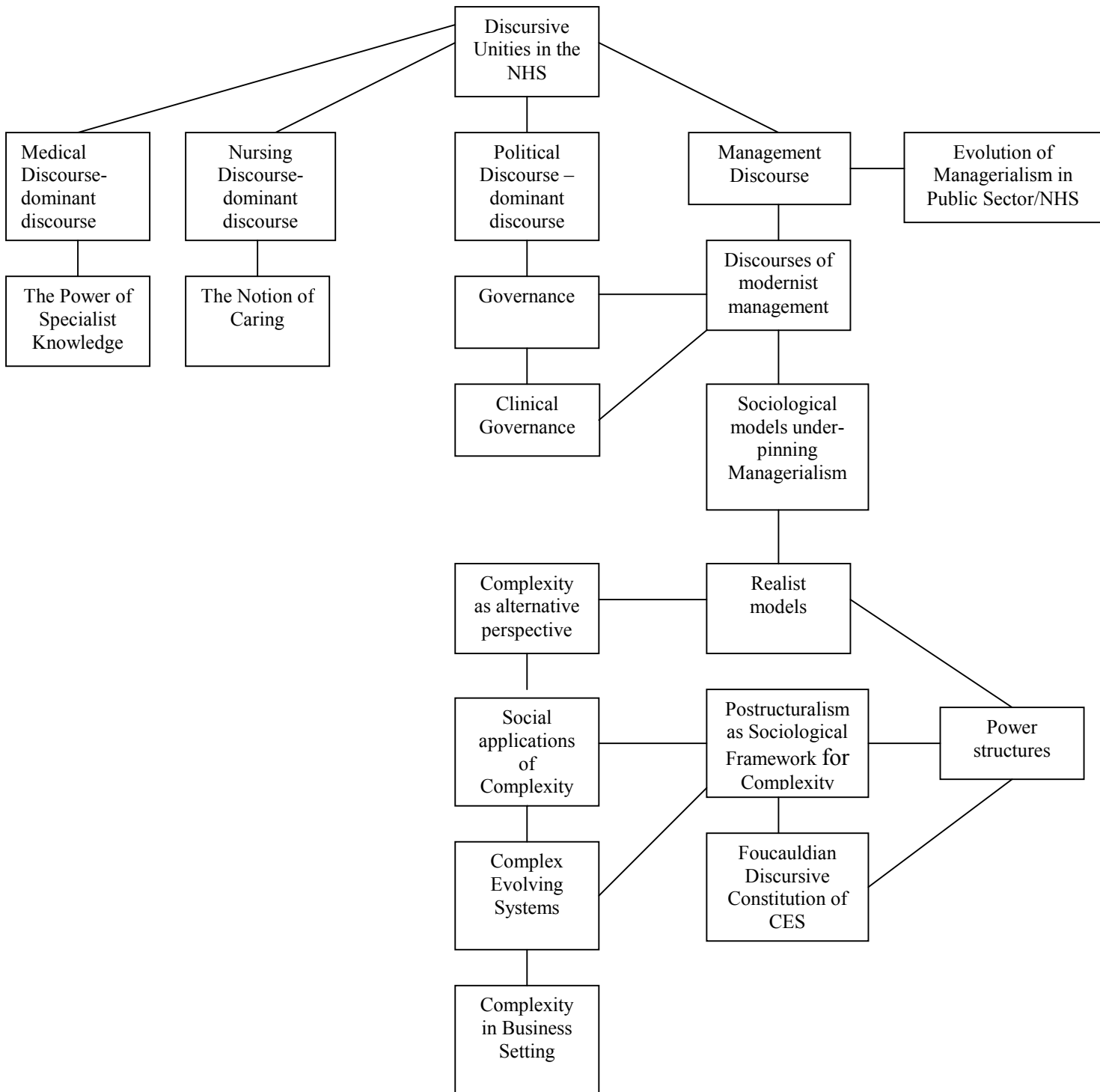
**Appendix IV:** The Participant Consent Form

**Appendix V:** The Researcher's Post Interview Reflections

**Appendix VI:** CD – Interview Transcripts on N.Vivo



## Appendix I: The Literature Review Pathway



## Appendix II – Letter of Approach

**business school**  
University of Glamorgan



Date  
Telephone (daytime)  
Telephone (evenings)  
E-mail

Address

Address

Address

Dear .....,

### **Power and Management within the NHS; A Complex Evolving System (CES) Perspective**

I would like to invite you to take part in this study, being conducted by Glamorgan Business School. The aim of the research is to explore the experiences of managers and clinicians in today's NHS and as an experienced member of the Trust your input would be most valuable. I am interested in how models of management from the private sector have been translated into the NHS and their effect on clinical and managerial level practice. The Cardiff and Vale NHS Trust have approved this study.

I am the main on-site investigator and I have many years hospital experience both as a manager and in the clinical field. The study will be contributing to my PhD with Glamorgan Business School. My conclusions are expected to inform political philosophy and stimulate debate around current public sector management strategy.

I have attached an information sheet describing the study in more detail and contact details if you wish to discuss this study further. I appreciate your taking time to read this within your busy schedule.

Yours sincerely

Jean Matthews

Glamorgan Business School



## Appendix III - Participant Information Sheet

### Power and Management within the NHS: A Complex Evolving System Perspective

You are being invited to take part in a research study being conducted by the Business School in the University of Glamorgan. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information and to decide whether to take part or not. Please talk to others about the study if you wish. The study will also contribute to my thesis for a PhD qualification in Glamorgan Business School.

#### **What is the purpose of the study?**

My research aims to explore the effects of managerialism on clinical and management practice in the secondary acute care sector of the NHS. Managerialism may be clarified in this study as the governments move to transfer private sector models of management into the public sector and their focus on performance management, targets and cost-containment. I am expecting that the conclusions will inform the academic, political and healthcare fields of the dilemmas resulting from current NHS policy and will endeavour to stimulate debate about alternative models of managing healthcare systems.

#### **Why have I been chosen?**

As a senior manager or senior healthcare professional in the acute NHS hospital sector I would like to interview you about your everyday experiences of the healthcare sector. I am hoping to recruit about 12 individuals to help with this research.

#### **Do I have to take part?**

Taking part in this research is entirely voluntary and you do not have to take part. If you do agree to take part you may keep the information sheet and you will be asked to sign a consent form. You are free to withdraw at any time without giving reason. If you decide to withdraw any information collected will be destroyed

#### **What will happen to me if I agree to take part?**

Each participant will be expected to take part in an in-depth interview about their experiences of the healthcare sector. The interviews are expected to take between 60-90 minutes although there are no defined limits. If you consent to be interviewed I will contact you to agree a convenient time and place. The interview questions will be lightly structured to allow you to talk freely and openly. I assure you that your taking part in this study will remain strictly confidential

**How will the data be stored?**

All interview data will be stored confidentially and securely, in line with the Data Protection Act 1998. The interviews will be audio-taped to aid transcription and the data codified and stored securely on my personal computer. Any data transferred to academic colleagues will be coded. It is expected that extracts of the interview text will be used in both my thesis and in any publications resulting from this thesis, but steps will be taken to ensure the anonymity of you and your designation in the Trust. The data will be destroyed five years after the completion of the research

**Expenses or payments**

There are no expenses or payments for taking part in this research

**Complaints**

If you have any concerns about any aspect of this study please speak to either my academic supervisor or me and we will endeavour to answer your questions. If you wish to complain formally, you can do this through the University of Glamorgan Complaints Procedure. Details can be obtained through the contact numbers below

**Who has reviewed the study?**

This research has been reviewed academically by Glamorgan Business School and has been approved by Cardiff and Vale NHS Trust. The South East Wales Local Research Ethics Committee has reviewed the research but considered that the study did not require their approval.

**Contact details**

If you wish to contact me about this study please feel free to do so. The Business school is closed during August, please e-mail or telephone.

Jean Matthews  
Glamorgan Business School  
mobile.....  
home telephone.....  
work telephone.....  
or e-mail .....

Academic Supervisor  
Please feel free to contact Dr. Thomas if you have any concerns about any aspect of this study  
Dr. Paul T. Thomas  
Glamorgan Business School  
Telephone.....  
e-mail .....

Thank you for taking the time to read this information sheet



**Appendix IV – Participant Consent Form**

**Power and Management within the NHS: A Complex Evolving System Perspective**

**Researcher – Jean Matthews**

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected
3. I understand that relevant sections of the data collected during the study may be looked at by responsible individuals from Glamorgan Business School, where this is relevant to my taking part in this research. I give permission for these individuals to have access to this data
4. I consent to the use of audio-tape during the interview, with the possible use of verbatim quotations and understand that the audio tape will not be immediately destroyed after transcription. The tape will be kept as a source data until it is no longer required and the will be destroyed
5. I agree to take part in this study.

Participant  
Name.....Signature.....Date.....

Researcher.....Signature.....Date.....

## **Appendix V - Researcher Post-Interview Reflections (transcribed verbatim from post interview notes)**

### **Interview One- Ward Manager**

Oh dear. Talked a lot less than I had hoped and I think I talked too much! A bit disappointed in my performance. Think I was expecting she would talk non-stop. On phone she seemed bubbly/willing to talk, now very bitter. I'm not surprised! - story about the medication error. She seemed wiped out, isolated, fed up. No support from above. Body language as interview went on became more closed.

Suppose interview wasn't that awful and she did say some really good stuff- not easy to talk free flow

Linear process of protocol led discharge good – good point about doctors not taking it on

Hierarchy came through and sovereign power – nursing hierarchy

Active listening is hard – tend to get involved with the story and not the underlying discourse. What I did note was that writing things down distracts them. It's too late at end of story though to come back and probe what they told you 30 mins ago. May change dynamic of conversation – brings to their attention that they have said something important/ significant- don't do. Besides the moment has passed.

The office we were in was not the best set up for interview as respondent was sitting awkwardly, not much I could do and recorder wasn't in best place- kept turning away from it.

I am not sure I expressed myself well with the questions although stories emerged and as long as they are talking past and present

Not sure if I captured what motivated her/ what she resisted. I need to check that I haven't coerced, I don't think I did I think I reassured and reiterated what she was saying -its very difficult not to talk to someone when they keep stopping.

My experience is a problem??? I feel I want to participate and it seemed like that's what was expected by respondent sometimes. She stopped and looked as if I should interact. I can't stay completely silent it wouldn't reflect a normal interaction. I think I had to empathise and support about error as this had really brought her down. I get too emotionally involved – but that's because I've been in same position – did this help or hinder – I think it probably helped – made it feel more trusting. I think she felt she could say things to a stranger though

Feel a bit drained myself- I don't think I prepared myself well. I need to have a bit more time to think before I go in, relax a bit.

### **Interview Two – Clinical sister**

Wow- much better, tried not to speak too much. Seemed to go on a very long time! Flowed well - lots of stories and the back up narratives could be heard.

Very little mentions of doctors- well problems with doctors. Lively, funny, subject motivated and happy to talk there was no concern about anonymity. Became emotional several times, almost tears at one point – notable change in expression Really good stuff too, kept talking about patients and caring discourse. Not sure if there were gender issues in here – nothing particularly noted

Stuff very detailed though, explained in depth about processes – possibly to emphasis a point - I had better conversation on phone when booking interview I wanted stories about her job/experience - perhaps she had pre-thought this through. Better interview set up too. More comfortable chairs, sat properly. Office small, dark, pokey, lots of cardboard boxes in corner, handbags on floor, drip stands, old PC, ledges dusty. Gloomy.

Started to see how stories bob back and forth over her life- emergent hey! This show that people do not talk in chronological order and think it covered history and present in fair depth – to what depth I'm not sure – sometimes I can see perfect bits coming out- how she created difference between management and clinical, managers do this we do that.

What was fantastic was that she said about this reflection she did – is this why she agreed to interview to back this up? Will send me a copy will be useful to compare with this interview- note contradictions- very few in interview- did not expect written evidence and this is a bit of a bonus

Lovely lady –really seems genuinely caring and emphasis on care and patients was amazing throughout. Controlling discourse evident- becoming evident with other interview- are they reacting by becoming more bolshy- raise voices – is this S.O – good story at end re fragmenting role of nurse

Noted symbolic stuff with sister and uniform – is this grasping on to old school

She ended perfectly herself – seemed better than last interview – rather a messy end with error story

Well, what about me- relieved and motivated, I was a bit nervous – no not the word- apprehensive – occasionally did not express myself well but did not use much jargon- although maybe not expressing myself well works to reduce power relations, lets them think they know more than I do – well they do. Didn't feel any one was dominant – allowed speaker to control direction

I could reflect on what she was saying and recognised similar situations to me and to first interview too- pattern starting? Did I sympathise – no did I empathise – yes. Did I encourage – nodding – yes. I naturally joined in a times – I did not actually ask second question storyline naturally emerged into this – maybe I said this when I booked so she new but I can't remember. Now I need to eat.

### **Interview Three –Directorate Manager**

Oh my God!! My first reaction is that this is an unmitigated disaster but something tells me that this is how it is and should be – its certainly emergent and unpredictable What I think I've got - soap box – emotional stuff too – values and beliefs, a lot of stress and anxiety about the system, a feeling of powerlessness- not emotion but passion for a system that is 'failing'. Needed to



see manager before he went home- to make sure she was off the premises, why?  
– trust? Allowed phones and bleeps to go continuously- show of strength??

I'm going home as tired and its almost dark so can't see to write in car.  
(continued after driving home....I talked to myself all the way home – should  
have taped this- feeling really despondent about content)

Well where did this guy come from. He was lovely but three and a half hours  
and I'm not sure if any of it was any good- cathartic experience for him- felt the  
need to raise his voice. I'm panicking and need to think – must be some good  
stuff in there although he wasn't talking about HIS experiences - there are  
stories just need to extract them from the trees and some really good comments  
especially about delay tactics, made me think of Seddon, inventory building.  
Financial came up time and time again. Lot about litigatory medicine- he sees  
beyond the system – can't co-evolve though

Maybe this is right – it should be different – different angle- sees different  
things – talks very objectively – acted as authority?? Spoke for the trust –  
different from the other two who saw a smaller part of system- he interacts with  
more 'systems' even if only through meetings/hearsay

Reflects different body of knowledge completely – clever, intellectual - no  
caring or patient stuff, only getting people home – throughput – targets – went  
on about all sorts of targets even though they were nothing to do with him

Surveillance – project of admissions – right first time

Relationships – manipulates – is this right word – consultants to meet his  
targets- I can't imagine anyone would argue with him- not enough time in the  
world for that. Yet he acted superior to them – position of power – how did he  
use this.

Has his own ideas to sell – are they his or is this coming from someone else, no-  
one listening to him- fragmented funding, hands are tied.

Well did I talk too much – unlikely – if I did he ignored me – I just made the right sounds to encourage him (obviously)

Okay – is this likely to happen again???? Should I stop this happening again - I need to keep more control perhaps, although I don't think anything I said would have worked. Need to say up front about asking questions - Thinking on it the way it started I wonder if the information leaflet had created the response. He didn't give me a chance to ask any questions at all, but I did get free flow narratives/stories and there was past present and future – will analyse this before changing my approach

Interesting office- naked apart from PC and a dead plant, no personal stuff, no pics. Derelict

#### **Interview 4 – General Manager**

Confidence almost restored- lovely guy, but back to square one as far as needing to keep conversation going. I think to talk free-flow must be difficult to just keep going. Seemed a bit short after last one.

Office very calm environment- conducive to 'thinking'. Staff in reception really pleasant. Office had big meeting table in centre and we sat opposite. Tidy – bit sterile, very hot!

Natural complexity thinker- he sees and talks interdependency – fantastic stuff about the evolution of pharmacy- never thought if this before- we had no blue print- just went out with some ideas and just did it- could be an article in this.

Lot about lean management but using this the right way – style of management very open and relational – getting people together – connectivity- the staff were the ones involved – not prescriptive change. Need to streamline processes – interdependency- never realised how fragmented it had become. He could see boundaries- the silo's – seems like consultants construct boundaries? – threat – survival – differs from pharmacy which is not consultant led – mix with others more

Not the manager I was expecting although again same thing said about being more objective – no perhaps not objective – seeing from a different angle – involved with more systems

Interesting about anti-coagulant chart- the need to change- delegation – saying what not to ignore- links with nurses story

### **Interview 5 - Clinical Governance Manager**

Went well again, not what I expected –work title supplied by personnel different – she is actually not looking after risk management as such. Complaints main role and deals with CHC. End difficult talking so quietly that the tape has hardly picked her up she was giving personal opinions about trust as if the chief exec was standing outside the door- money given but goes on monitoring, monitoring the monitors excellent.

Not getting GPs involved early enough – she naturally sees the lack of co-evolution – boundaries funding again – the need for trust to do this is important – survival instinct??

CHC- Execs speak in jargon, above their heads - boundary

Fab story about SPI everything is SPI SPI SPI- work hard on this for six months then it never comes to fruition- top down initiative mirrors nurses stories

- Targets - this is what's driving US
- RTC- agree, everybody trained nobody uses it

Couple of long-winded stories but the contrast – her relational style – when she can sort things for herself otherwise gets all out of proportion- everybody involved, documentary evidence

Trust needs more autonomy- WAG guidelines for complaints unworkable- everyone uses different definitions – target driven

Surveillance culture is clear

Personally thought this went well, loosened up as interview progressed – again why agree to interview – need someone to talk to?? Manager thinks she gets too involved

I controlled myself much better but had to intervene at end because she was talking so quietly – moved tape closer – started reiterating what she said so that I could remember conversation – not coercive I don't think

Office is cosy, homely, pictures of family on window sill. Loads and loads of files and documents though.

### **Interview 6 – Intermediate Care Manager**

Met me in reception – little bit nervous, wanted to talk in café but it was too noisy – why though – fear of being overheard? Think she was a bit worried about talking at her office but we went into 'relatives' room – nice sofas and coffee tables – warm and comfy. Settled down after 15 mins but I felt she was guarded – yeah good word – open, trusting but wary- of what

Realising now that they are not talking targets at clinical level – not what I expected- my presumption about targets affecting their work is not justified.

Seeing split between managers who have PM role and those who are co-ordinating work- trying to cope with system boundaries evident here again – her whole role is doing this – work is about DToC though – this is it – not targets as such – needs connectivity and informal communication- shadow - check

Interview reinforces fragmentation of nurse role – I wonder if this is a talking point in nursing, seem to keep hearing- she may know others as has worked previously on unit

I felt I asked questions better, neutrally and didn't get too involved allowing freedom to talk. Active listening skills getting better – looking for the underlying in what she is saying – need to keep finger on pulse though. Still finding it difficult to remember a point from earlier on – feel I need to probe

sooner rather than later, can't reintroduce subject later on doesn't fit -  
???coercive maybe

Mentioned census and forgot to ask what it was- need to find out what census is  
about – sounds surveillance- by whom – WAG?

Interesting point – I thought that each respondent so far had spoke as  
enunciative function – they are their own authorities to some extent- stating their  
own discourse whether marginalized or not – but this interview is only just  
realising this- that she can act/state with authority – up 'til now she feels that she  
must go up the ladder for approval – but when she does she doesn't get it – she  
has the power but institutionalised cant accept that she can.

### **Interview 7 – Consultant**

Hysteresis – not system/ agent – wrong word- his history and past experience  
notable difference – not picked this up before in interviews – has no baggage –  
will affect the way he interacts with discourse – more accepting – consultant  
contract story – noted irruption early on in story on doctors hours –  
exacerbation.

Not at all what I expected – not really what I wanted but this is what its about.  
Young consultant – not stereotypical rant. Little disappointed – too nice BUT  
said some good things. Interview bit quiet could not always understand what he  
was saying and automatic air con in background not helping. OK.

Different style – relational/patient focus/ working together had driven change-  
not driven – Power of consultant more obvious in one story – acts as authority of  
delimitation – power-knowledge of medical autonomy. He convinced the Med  
Director that project could work - med director would have same values?? No  
same experiences. Nurse led change not strong enough (nurses stories) .Not  
mentioning discharge in same way – more detached from this process – a step  
away- but discharge is the theme

Fantastic story about commissioners – subjugating his views and not involving others who might act as powers for the people/the voluntary sector.

Needed this consultant to get the medical perspective – need to balance out the nursing - I feel I'm getting too much data, so much going on- I need to narrow the focus. Can I see patterning- certainly themes are emerging certainly discharge. I've had enough today, I feel a bit emotional about all this. These are all really nice people, committed but almost drowning without support. Maybe I'm seeing this through my experiences – there not cold interviews – things have struck a chord, reminded me of work, bad memories.

### **Interview 8 - Medical Director**

Last one over and I must admit I'm relieved – lovely gentle chap and was useful but I'm beginning to get the feeling that the unstructured interview is too difficult in this situation. May be better to put some bland questions to them to keep the conversation going. It is possibly because of preparation, if you are talked about a problem you have it is easy to talk especially in the researcher has told you before hand that they expect you to talk. This situation different- think they have time to think' before hand of what they want to say- needed to keep kick starting this toady and I am surprised it lasted 56 minutes.

Not sure he really wanted to do this – no passion, very level headed, body language started a bit closed but relaxed about half way through- I tried to lead this by taking a more relaxed pose – did it work?? Not best set up – either side of large table again- I'm sure this is for big office meetings but it looks like a defence- nice office though

Also I feel I am getting 2 categories of people here- very wrong to categorise I know but there seems those who want to be interviewed to raise their voice – feel need to be listened too? And there are those who I think just want to be helpful, to help a colleague or student out. I don't know

Content was a bit sparse but this guy did give me some useful stuff. Will definitely add to other profiles. Doctor-manager relations Drs need more management training- is this a means to regain the power and control over

discourse? Mentioned team working – doctors indoctrinated by their consultants- close ranks. Not really getting his values etc but did mention efficiency discharge quite a bit

Noted word protection at ward level- close ranks – good

Me- well I think I was relaxed and I don't think I coerced- mostly built on what he said. Pretty much conversation at one point. Very little power differential I think he realised I knew what is happening in WAG and if anything trying to pretend you don't understand is more difficult. Good day