Understanding organisational change: discourse, technology and social relations

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Abstract

This paper illustrates the use of Law’s (1991a) concept of discursive strategies of ordering for making sense of the ordering processes that constitute organisations and organisational change. It does so via a case study of change in a New Zealand hospital during a period of public sector reform. The “clinical leadership” ordering strategy introduced into the hospital at this time was simultaneously discursive in its appeal to economic notions of efficiency and enterprise, material in its use of information technology, and relational in the development of new accountabilities and relationships within the organisation. The paper highlights the materially and relationally heterogeneous nature of organisation as performed.

Introduction

There is a growing body of work that views organisation as a social process that is constructed, performed and experienced (e.g. Brunsson and Sahlin-Andersson, 2000; Keenoy et al., 2000; Parker, 1997). The key element in these perspectives is that organisation is not a stable and static social order, but an ongoing multiplicity of attempts at ordering (Law, 1994). Any apparent stability is the result of more or less successful attempts at building networks of relationships amongst the heterogeneous actors that inhabit the organisational space (Law, 1991a). In this sense, organisation is the language, practices and techniques through which people govern the conduct of themselves and their relations with other actors (cf. Hull, 1997).

If we adopt such a perspective of organisation, then changing organisations involves building a network of relationships between organisational entities that are defined and shaped (against various resistances) to contribute towards some particular goal of change (Law, 2000). Or, as Brunsson and Sahlin-Andersson (2000) suggest, the construction of entities so that they come to resemble some general or abstract concept of organisation – perhaps one that is perceived to be somehow more “complete”. In the context of recent public sector reform in a number of Western countries, much organisational change can be seen as representing attempts to reconstruct public sector organisations as more consistent with popular notions of “modern management” taken from the private sector. This paper describes such an attempt to make a New Zealand public hospital more “business-like”.

The research reported in the paper is drawn from a longitudinal study of organisational change in a single New Zealand hospital, Central Health (not its real name), between 1994 and 1996. As in the UK, health care in New Zealand during the 1990s was problematised by recourse to a discourse that redefined performance and efficiency in economic terms, and framed clinical issues in the language of the market. This problematisation legitimated the corporatisation of New Zealand public hospitals, and demanded the introduction of private sector managerialism into a domain previously dominated by health care professionals.
At Central Health, governmental intentions to contain the costs of health care delivery by ensuring greater accountability for clinical resources consumed were translated by senior hospital managers as a requirement to incorporate clinicians more fully within some system of organisational control. In an attempt to achieve this, a small group of corporate managers promulgated a strategy of “clinical leadership” that was intended to reorganise the hospital and the clinical activity that occurred within it by constituting clinicians as managers. This strategy replaced earlier attempts to impose management on clinicians, with a more subtle intention to win clinicians over to managerialist values and thinking (cf. Dent, 1993; Malcolm and Barnett, 1994).

This paper uses the localised setting of the hospital to construct an account of organisational change that draws together the (mutually implicated) discursive, social and material dimensions of organisation. As such, it is itself an attempt at ordering, and represents one possible narrative of the perceived social process of organisation. The primary source of data came from extended informal interviews conducted at the hospital between 1994 and 1996. A range of people from all levels of the organisation were interviewed and observed. In total, 70 interviews were conducted, spread over some 60 hours. The interview data were complemented by a review of organisational documentation and observation of meetings, seminars and other hospital activity.

The paper is structured as follows. First, the notion of “discursive ordering strategies” (Law 1991a) is introduced as a conceptual device for understanding organisational change. The change story from the hospital studied is then told, before the theoretical apparatus outlined earlier is used to try and make sense of the organisational change attempted in the hospital. The paper ends with some concluding remarks.

**Discursive ordering strategies**

In discussing organisations, Law (1994) rejects the notion of a single, purely social order. Instead, he suggests that there are plural and incomplete attempts at ordering. What appears as ordered stability is in effect the outcome of these ordering processes. In other words, organisation is a performance, rather than an end (Parker, 1997). Law (1991a) suggests that social relations are to some extent strategically organised (in a local, empirical sense). He discusses the notion of “discursive strategies of ordering”, which draw upon a variety of different organising principles, discourses and practices. Discursive ordering strategies are attempts by various actors to order the organisation and work of others. They offer a way to theorise about organisational change – about how organisational practices are instituted and regulated, and how organising occurs in the various mechanisms of ordering and controlling employed by organisational participants.

Ordering strategies in organisations can be conceptualised as “heterogeneous engineering” (Law, 1987), involving the construction of actor-networks (Callon, 1986a; Latour, 1987; Law, 1992). These sociotechnical networks simultaneously concern the nature of things, collectivities and social context, and the meaning effects of discourse, while not being reducible to any one of these (Latour, 1993). Organisation, then, and the ordering attempts that comprise it, are at once material, relational and discursive.

Organisation is relational in that organisational actors, both individual and collective, are defined and interactively constituted in their relationships with other elements in the actor-
network (Law, 2000). Differences in agency and size between actors are the result or outcome of some process of negotiation, involving power relations and the construction of networks (Callon and Latour, 1981). All are relational achievements, uncertain effects generated by a network and its mode of interaction. They are constituted as objects only to the extent that the network stays in place (Law, 1994).

Networks of ordering come in a variety of material forms, such as people, texts, machines or architectures, and these materials are not given in the order of things but are provisional and susceptible to change (Law, 1994). Organisations and social relations are made relatively cohesive and stable by the way they are intimately bound up with the technical (Joerges and Czarniawska, 1998; Latour, 1991). The ordering of the social is never purely social, but rather sociotechnical, in that the social and the technical mutually define one another (Knights and Murray, 1994; Law, 1991b). The corollary is that society and technology cannot be conceptualised as two ontologically separate but interrelated entities. Technology and organisation cannot be separated out. Each presupposes the other (Bloomfield, 1995; Bloomfield et al., 1994). This requires that the dualism usually assumed between the technical and the social be replaced with a view of reality as materially heterogeneous. In this view social and technical relations are embodied and played out in the ordering of technology and organisations (Latour, 1994; Law, 1994).

Actors draw upon a variety of different discourses and practices in their attempts to order the organisation and work of other actors. These discourses and practices are not given or natural, but arise within secure and legitimate power/knowledge relations, often articulated at a broader societal level. Thus, power is an irremediable aspect of the formation or transformation of the materially heterogeneous networks implicated in ordering strategies (Knights and Murray 1994). Power (Foucault, 1980, 1982) achieves its effects through discourse and the reproduction of discursive practices. Discourse refers to the language, ideas and practices that condition our ways of relating to, and acting upon, particular phenomena (Knights and Morgan, 1991). Individuals come to understand the world in the terms of the discourse and social practices that reproduce this world-view as truth.

Various sources of expertise, whether professional or managerial, lay claim to the truth. They create normalised knowledge, operating procedures and methods of inquiry, and translate lay problems into expert languages, suggesting that their knowledges and techniques can solve these problems, and shaping conduct (Miller and Rose, 1990). The development of knowledge and expertise privileges certain notions of what is real or true, and enables the qualification or disqualification of certain ways of knowing and acting (Deetz, 1992). Actors utilise particular discourses to interpret or construct organisational reality in such a way as to justify or legitimate particular actions or outcomes (Knights and Murray, 1994).

To study ordering strategies and the construction of sociotechnical networks is to explore how various ordering attempts are acted out and told in different materials, and the way in which they interact and change. In these strategies, entities seek to establish themselves as agents, building a network of alliances by constituting, mobilising and juxtaposing a set of materially heterogeneous elements, obliging them to enact particular roles and fitting them together to form a working whole (Law, 1988). The agent becomes the spokesperson of the actors constituted in this translation (Callon, 1986a, 1986b):

Translation builds an actor-world from entities. It attaches characteristics to them and establishes more or less stable relationships between them. Translation is a definition of roles, a distribution of roles and the delineation of a scenario. It speaks for others
but in its own language. It is an initial definition. But ... no translation can be taken for granted for it does not occur without resistance.... Successful translation depends upon the capacity of the actor-world to define and enrol entities which might challenge these definitions and enrollments. (Callon, 1986a, pp. 25-26)

The enrolment of allies in a network involves translating imputed interests (Callon and Law, 1982), persuading other actors that they share a common interest or problem. The agent seeks to enrol other actors into a network by a process of problematisation (Latour, 1987), presenting a problem of the latter in terms of a solution belonging to the former. Alternatively, by equating two problems, different actors can also become bound together in solving that common problem (Bloomfield and Best, 1992). Note, however, that these processes of translation and problematisation are not unidirectional. Actors are invariably self-interested, and network building is thus a process of mutual enrolment and shaping (Bloomfield and Best, 1992; Law and Callon, 1992).

The insertion of various translated and enlisted actors into a network of heterogeneous relationships involves the simplification of actors, to certain well-defined characteristics or attributes which are compatible with the relationships established between actors. In this way, objects achieve relative durability and confront agents as simplified units. That is, the actor-network is a network of elements, each of which is the simplification of a network of other elements. In this way, a network may be durable because each of its actors constitutes a durable and simplified actor-network (Callon, 1986a; Law, 1988; Law and Callon, 1992).

However, network ordering is uncertain, contingent and transient. The stability of a network lasts only as long as its constituent actors do not resist the role or definition they have been enacted to fulfill. If one of the actors enrolled in a network resists enrolment and defines itself differently from its simplified definition (that is, the simplification fails), the actor becomes complex, possibly leading to the modification or disintegration of the network (Callon, 1986a, 1987). Thus, even apparently stable actors such as large organisations may disintegrate if the network for which they front and speak for is not kept in line (Callon, 1991; Law, 1992, 1994).

The concept of a discursive ordering strategy, and the network building it attempts, is used in this paper to analyse an instance of organisational change in the hospital studied, Central Health. To familiarise the reader with the context and details of this change episode, a brief narrative is presented in the following section.²

All change at Central Health

Central Health was a hospital in turbulent times. Dramatic changes in the political and economic governance of public health in New Zealand had contributed to an environment characterised by increasing uncertainty (cf. White 2000).³ Within the hospital, continuous change had created anxieties as traditional images of caring and cooperation confronted a new language of economic rationalism, and as managers imported from the private sector attempted to secure commitment to change from disillusioned health care professionals.

The latest source of turbulence was the resignation of the hospital’s CEO, a well-respected surgeon, in mid 1995. Initially a supporter of the health reforms instituted by the incoming government in 1991, he had become increasingly disillusioned with the continued
requirements for operating efficiency and rationalisation placed on him by central government (Lawrence and Doolin, 1997). Apparently, “unresolved conflicts” with the government-appointed Board of Directors, and with some of the “stronger personalities” in the hospital’s senior management group, were a factor in the resignation. A new CEO, an accountant, was appointed from within the senior management group at the end of 1995.

Under pressure from central government to reverse large operating deficits, and faced with increasing dissatisfaction of hospital staff with the general management structure that had been put in place since the hospital was corporatised in 1993, the new CEO sought a fresh approach to organising the hospital. Inspired by accounts of the experiences of several UK hospitals in facing similar financial crises, the CEO decided to introduce an organisational structure based on the clinical directorate model (Ham and Hunter, 1988). In this model, semi-autonomous business units are based on service specialities and headed by a senior clinician, the clinical director. The unit director is the unit budget-holder, and is supported by one or more full-time managers, either from a nursing background or (less often) a business manager (Harrison and Pollitt, 1994).

A small group of corporate managers began working on a business plan intended to eliminate the hospital’s large operating deficit within three years. This change management group was composed of the new CEO, three corporate managers, a management consultant and the Board Chairman. While there was some scope to reduce the hospital’s operating deficit through increased revenues, the perceived challenge was to reduce overheads and to create changes in clinical practice. The new organisational structure of clinical units was designed to achieve both of these objectives.

In particular, there was a pragmatic realisation that general management had been unable to change clinical practice, and a new ordering strategy was developed around the discursive notion of “clinical leadership”. Clinical leadership involved the devolution of responsibility down to the level of clinical specialty, so that resource use could be more closely monitored, and the resource implications of clinical decision-making could more clearly be made visible. Accountability was to be moved one step closer to the patient, in an effort to encourage a change in clinical behaviour.

The new organisational structure was implemented in early 1996. The restructuring was based around the construction of clinical units, and attempted to align the government’s method of funding with the hospital’s business processes. Each clinical unit had at least one contract with the local purchasing authority. A high correlation between primary contract and clinical speciality meant that there was an identifiable revenue flow for a particular service. Fifteen clinical units were defined, each headed by a director who was normally a clinical consultant in the speciality around which the unit was arranged. Five clinical service units were constructed along similar lines to the clinical units.

Clinical unit directors were typically appointed from within the group of senior clinicians in each speciality. The unit director was accountable for the clinical and financial performance of the unit, including clinical outputs, cost management and contract negotiation with the local purchasing authority. Unit directors were each supported by an operations manager. Business managers provided a consultant-type role to operations managers and unit directors. The unit director role was considered to be part-time, and was normally combined with clinical practice.
To facilitate organisational change, assumptions about the appropriateness of what was done in the past were changed and organisational history was to an extent re-written (Parker, 1997). The change management group portrayed the old divisional structure as outgrown, in order to make room for the new organisational structure. With the introduction of general management into Central Health, emphasis had been placed on importing the necessary people and skills from the private sector in order to accomplish change. This process was now rationalised as a transitional phase that had served its purpose. The development of financial, information and management reporting systems was now largely completed, and the old structure was described as adversarial and inhibiting information flow. In contrast, the new organisational structure would encourage “a mix of entrepreneurialism tempered with common sense”, and balance medical collegiality with responsiveness and business-like behaviour.

While a group of senior clinicians at Central Health were involved in demanding change, senior management effectively captured the change process and clinicians were sidelined from significant involvement in the restructuring. Consultation was largely limited to seeking feedback on the change management group’s ideas. As one senior clinician observed: “There wasn’t a formal involvement of clinicians in the change management team, to help with that process. And yet they’re appointing clinicians to run the business” (Interview with Director Oncology, Central Health, March 1996). Another interviewee suggested that this was “restructuring by stealth” – a deliberate strategy adopted in the face of entrenched organisational cultures.

From management’s perspective, getting clinician buy-in to change was always going to be difficult. A senior manager argued that without the perception of a real threat, the change process would not be facilitated:

Now you ask yourself “What’s happening here at [Central Health]?” The answer is the threat has never been perceived to be real ... That’s made it very difficult to institute change, or to get the need to change accepted. (Interview with General Manager Business Services, Central Health, March 1996)

The clinical leadership ordering strategy described above was an attempt by management to increase control over the decision making of a relatively cohesive and powerful medical profession committed to retaining their professional autonomy (Coombs, 1987). The intention was to ensure greater clinical accountability for the resources consumed as a consequence of clinical treatment decisions. In this ordering strategy, the perceived requirement to control clinicians was problematised as a need to enrol clinicians in their own control as clinician managers. To achieve this, managers at the hospital attempted to construct an actor-network, using various tactics of problematisation, translation, and enrolment. In doing so, they made recourse to a number of discourses prevalent in society or introduced into the hospital during the public health reforms of the early 1990s, and attempted to define particular roles and relationships for the actors they were constituting. These themes are explored in the following sections in an attempt to make sense of the ordering involved in the clinical leadership strategy.

**Problematising health care**

In problematising health care, different actors invoke particular discourses in order to influence the definition of the problem. These discourses are interpreted and negotiated as
various ordering attempts proceed. At a broad governmental level, an ideological acceptance of economic rationalism encouraged the development of a new discourse in health care in the public sector in New Zealand. This discourse is characterised by the importation of values, techniques and skills from the private sector in the espoused pursuit of efficiency, value for money and greater accountability. In the context of New Zealand health care, the management discourse associated with the public sector reforms provided a frame and vocabulary with which parts of government, business lobbies and health administration were able to define a health care problem and solution in terms of managing health care:

Funding of healthcare services … is now placing much greater emphasis on effectiveness, accountability and value for money. There is a determination to ensure that the community gets the best return for every cent it invests in healthcare. This means a significant change to the business of healthcare services delivery, bringing it into the mainstream of the modern commercial environment. (Neame, 1997, emphasis added)

When the imagery of the profit-seeking enterprise is applied to health care management, the hospital becomes redefined as a multi-product factory. Patients become products, subjected to standardised treatments with standard costs, and clinicians become managers, responsible for those costs (Bloomfield et al., 1992; Chua and Degeling, 1993). This hospital-as-factory analogy made its way into Central Health, where the production line became the dominant metaphor for health care management among the hospital’s managers. In this conceptualisation, clinical care was translated into patient flow management, which in turn was translated into production line management. In other words, “just logical production flows which need to be managed” (Interview with CEO, Central Health, May 1996). As one of the hospital’s senior managers explained: “Efficiency in a hospital, I believe, is getting as close as you can to a manufacturing process.” (Interview with General Manager Support Services, Central Health, August 1996)

The problematisation of health care through recourse to a discourse that redefines performance and efficiency and frames clinical issues in the language of the market enables the provision of a solution in which clinical practice and the use of clinical resources become constituted as objects of management. When clinicians at Central Health resisted the introduction of general management, the discursive ordering strategy of clinical leadership presented an alternative solution in terms of enrolling clinicians in their own management. Managing clinicians and clinical activity became problematised as exercising influence over clinical professionals rather than direct control over their behaviour.

Framed as a lack of clinician involvement in the management of the hospital, managing in this new translation meant getting clinicians to “own the problem” (presumably management’s problem) and take action (Thorne, 1996). This attempted acculturation of clinicians to management was presented to clinicians in terms of their own empowerment (so that they could control what happened to their practice):

My project is to make the clinician the utilisation manager. So we’re bringing to them the empowerment to be their own utilisation manager, thereby instituting their own efficiencies. Well, hopefully practising with effectiveness in mind, bringing about their own efficiencies. Controlling what they can in their own service. Empowering them. And hopefully by doing that, the institution as in your organisation gets what it needs out of it … The concept is simple, the politics are difficult. (Interview with Clinical Casemix Project Leader, Central Health, August 1996)
Statements such as this explicitly present clinicians as managers (a definition that many clinicians would dispute), and vest control of and responsibility for resources in their hands. That is, they attempt to construct clinicians as managers and as users of management information:

Hospitals have been faced with the task of simultaneously creating management information that could be acted on by doctors, and manoeuvring those doctors into defined positions where they accept such responsibility. (Bloomfield et al., 1992, p. 199).

Translating interests

To constitute clinicians as managers, the change management group at Central Health needed to enrol them (and other actors) in the discursive notion of clinical leadership. In other words, to enrol organisational participants as allies in the incipient network of ordering, the change management group needed to translate the imputed interests of various actors in such a way as to persuade them that the new strategy of clinical leadership was relevant to them. As agents, the change management group sought to define the nature and the role of these actors. Actors could of course define themselves differently, thereby resisting simplification and enrolment. Successful translation depended upon the agents’ ability to define and enrol actors who might well challenge these definitions (Callon, 1986a). In particular, the change management group needed to define and mobilise a role for clinician managers within the hospital.

The change management group deliberately sought out senior clinicians with perceived sympathetic interests as potential allies capable of championing the organisational change involved:

Basically the clinicians who are showing interest, who show interest in the costs and, you know, who take it on board as part of the practice, and who have every intention of sharing it and introducing it to the practice of medicine, they’re the ones basically who have been appointed as the clinical unit leaders. You know, they’re the ones that are turning into your clinician managers. (Interview with Information Systems Manager, Central Health, August 1996)

These clinicians exhibited an interest in management and seemed to find the new clinician manager roles challenging. They were deliberately developing more managerial skills and knowledge, including formal management education. Several had recently completed MBA. Working more closely with managers, together with the reframing of clinical issues and their expression in economic terms using management tools such as budgets and contracts, had contributed to the managerial acculturation of these unit directors at the hospital.

However, enrolling clinical unit directors from among the senior clinicians in the hospital was not as successful or as straightforward as perhaps had been anticipated by the change management group. Most senior clinicians did not define themselves in the role of clinician manager articulated for them in the clinical leadership strategy. For many, management was something separate from medicine. It was “esoteric” and involved “a different jargon”. Comments such these reflected a desire to remain removed from involvement in management. Indeed, clinicians who expressed the desire to become clinician managers were often viewed with suspicion by their colleagues.
More frequently, the role of clinical unit director was redefined by the senior clinicians in a specialty to reflect the traditional mode of organisation among hospital clinicians, which involves professional and collegial relationships (Ham and Hunter, 1988). These unit directors tended to act as a buffer between their medical colleagues and the demands placed on them by management, so that the actual internal operations of the unit remained decoupled from the formal organisational structure. Despite the intention of management to enrol senior clinicians who would champion change, clinical unit directors tended to be “change absorbers” rather than “active colonizers” (Jacobs, 1995).

The clinical leadership ordering strategy can be interpreted as an attempt to influence clinical behaviour through cultural change within the medical profession by diluting or undermining professional values and norms with managerial ones. In this sense, clinician managers play a boundary role between their professional colleagues and management. However, the effectiveness of the clinical leadership depended on the acceptance of the clinician manager role by other clinicians and organisational participants. By accepting the role and legitimacy of clinician managers, other clinicians reproduce the discursive practices based around clinician management. In doing so, their own subjectivity may be acted upon so as to accommodate the new understanding of organisational reality and the criteria for decision-making provided through these discursive practices.

**Tactics of enrolment**

One discursive practice in particular, “casemix management”, was promulgated throughout Central Health. Casemix management is an attempt to manage or regulate medical practice in relation to the consumption of resources across a range of patient categories. Casemix management systems provide detailed individual patient activity data that can be aggregated and costed (Packwood et al., 1991). This information ostensibly allows the evaluation of hospital sub-units, or even individual clinicians, in terms of profitability.

Underlying the introduction of casemix management in hospitals such as Central Health is a belief that much of a hospital’s resource expenditure is due to patient treatment decisions by clinicians:

Clinicians are the largest consumer of the hospital’s resources ... In the way that the health care system is currently working in New Zealand, the clinician will always have the end decision ... He is the one that decides if that patient gets the bed or not. He is the one that decides what the patient’s pharmaceuticals are going to be. He decides what the patient’s tests are going to be. (Interview with Clinical Casemix Project Leader, Central Health, September 1996)

Such attitudes form the justification for management scrutiny and intervention in clinical activity, whether directly or indirectly.

Clinician involvement in casemix management at Central Health was essential in sustaining the legitimacy of the casemix system. The active cooperation of clinicians and other health professionals is required in the operation of such accounting and control systems designed to monitor medical activity (Coombs, 1987). However, enrolling clinicians in casemix management required a demonstration that it would facilitate better patient care. In an attempt to sell the benefits of casemix management to clinicians, a clinical casemix project team was
formed in May 1996. This team conducted presentations on casemix management to groups and individual clinicians, specifically targeting the clinical utilisation of casemix information.

Various tactics of enrolment were employed to interest clinicians in casemix management. The general approach adopted was to focus on the notions of best practice and patient care. Cost information was to a large extent de-emphasised. Recourse was made to a quality discourse in an attempt to construct the interests of clinicians as congruent with those of management. This involved translating the notion of patient care in terms of effectiveness and efficiency:

Utilisation management [casemix management] is basically a process to improve the quality of care through the efficient and effective use of resources. Effective is your quality. Effective is very much representing your quality, and effectiveness is basically the target that we’re using for the clinician population because that is still their number one. You know, they want to provide quality patient care. (Interview with Clinical Casemix Project Leader, Central Health, August 1996)

Inscriptions produced from the casemix system were a powerful aid in demonstrating the benefits of clinical casemix information. Various reports and graphs were used to interest potential users in the range of information available. Examples of clinical casemix information included measures of length of stay, same day admissions, day surgery versus inpatient surgery, operating theatre time management and off hours laboratory usage. In providing this information to clinicians, the intention was to interest them in monitoring the resource consequences of their treatment decisions in the hope that they would modify their clinical behaviour towards efficient practice.

If you get into true effectiveness, meaning that your resources are being used appropriately ... then you’re going to come out with efficiency. (Interview with Clinical Casemix Project Leader, Central Health, August 1996)

However, with a few exceptions, the clinicians at the hospital had a poor opinion of the validity of the casemix information and expressed little interest in using it to inform their practice. This disinterest by clinicians in the casemix information stems from several sources. The casemix system at Central Health was largely dominated by financial and costing perspectives and had produced little information of perceived clinical relevance or benefit. The low regard many clinicians have for accounting information and the occupations associated with its generation and processing, also presented a major difficulty in enrolling clinicians (Bloomfield et al., 1992). Finally, there was a reluctance on the part of clinicians to have their practice scrutinised and their clinical freedom potentially infringed upon.

Defining accountabilities and relations

Within Central Health, the privileging of managerial or economic discourses included the shifting of priority towards financial and quantifiable measures of efficiency, effectiveness and performance. The definition of clinical specialties as semi-autonomous business units and the introduction of a standard contribution report for each unit were ways of measuring financial and contractual performance, and of focusing management attention on profit and loss making areas. This encouraged an understanding of organisational reality grounded in economic notions of value and commodity. The visibility given to concepts incorporated in these reports, such as profit or loss, average length of stay or performance against contract
volume, introduced new practices of accounting for clinical performance and new accountabilities for clinicians.

Clinical unit directors were accountable for the clinical and financial performance of their units. By assuming responsibility and accountability for the efficient performance of specific activities and for their outcomes, these units of management were in effect affirming an entrepreneurial identity consistent with discourses of management and enterprise (du Gay, 1996). Contracting was given a fundamental role in the purchase and provision of health care in the reformed health environment, with the contractualisation of social relations occurring between institutions and between individuals and institutions (cf. Lane, 1999). Clinical unit directors were responsible for the negotiation of contracts with the local purchasing authority. This consumed a significant amount of their time, and involved the reproduction of casemix management information and practices.

The implementation of clinical units at Central Health was based on the assumption that clinicians are the natural managers in that they determine the type and intensity of services required for treating each patient (Elston, 1991). Just as the introduction of new management and economic discourses into the hospital tended undermine alternative medical or professional perspectives, the clinical leadership strategy gave centrality to clinicians, contributing to the relative marginalisation of other health care professionals such as nurses. Before the introduction of the clinical leadership strategy at Central Health, management of clinical specialties was typically performed by ex-nurses, and several had been appointed as general managers. The notion of clinical leadership and the subsequent restructuring around clinical units effectively handed line control of clinical areas to the new clinician managers:

Now the nurses had quite a different view of this. Because the nurses had struggled for many years to become equal clinical professionals with doctors. Different but equal. Not Florence Nightingale, scrubbing brush, “Would you like a cup of tea dear?” … This model was seen to just re-empower the doctor and subordinate or subjugate the nurse in the relationship. So that brought it’s own set of tensions into the debate. (Interview with General Manager Business Services, Central Health, March 1996)

Other health workers resisted the simplifications of the roles envisaged for them by the change management team. Radiology, for example, was initially identified as a hospital-wide support service since it had no direct income from a purchasing authority contract. However, the attempt to locate Radiology in the Support Services division triggered a strong protest from radiologists. The role defined for them by the change management group conflicted with the definition of expert identity held by these allied health professionals, who considered that “they hadn’t trained professionally to be lumped in with the Laundry”.

Inscribing organisation

At Central Health, the discursive ordering strategy of clinical leadership was deployed in an attempt to construct an organisation based around the development of clinical units and the introduction of clinician management. The materially heterogeneous nature of the resultant sociotechnical network was expressed in the enrolment of the information technology utilised in casemix management. While the casemix information system and the development of clinical units had separate origins, they became progressively interwoven in the stabilisation of this network of ordering within Central Health (cf. Bloomfield et al., 1994). The
development of clinical units at Central Health presupposed a casemix information system that provided a window on organisational practices. At the same time, the development of the new organisational structure gave the casemix information much of its perceived significance, both in terms of contract management and the accountability of unit directors for both clinical and financial outcomes.

For instance, the casemix information system offered a way to “break the organisation down” into visible and manageable parts built around identifiable revenue streams related to clinical specialties. Information from the system was needed to coordinate the movement of patients between the new clinical units, and to match the associated resource utilisation with the relevant purchasing authority contracts. The casemix system was intended to facilitate decentralisation of responsibility to clinical unit directors and to encourage flexible operations. At the same time, it provided a more centralised monitoring and scrutiny of the activities of the decentralised clinical units (Orlikowski, 1991).

Delegating meaning and action to the inscriptions produced from the casemix information system helped reinforce and stabilise the new organisational structure (Bloomfield, 1995). The information system played an important role in mobilising the concepts and norms associated with the new economic and management discourses. It offered an apparently concrete (although partial) representation of organisational reality, which helped give meaning to the various transactions and organisational practices in which it was utilised. To the extent that organisational participants drew upon the information, rules and resources embodied in the casemix information system in their daily activity, they reproduced and reaffirmed its importance, form and content (Bloomfield and Coombs, 1992).

The casemix information system was implicated in the daily work of many organisational participants, providing a technical vocabulary to mediate the meanings given to events and relationships such as those between clinical units or with the purchasing authority (Orlikowski, 1991):

Casemix has become a part of the way we work. Just a day-to-day thing we’re utilising ... I mean, one’s using it all the time. Whenever we’re doing presentations or developing stuff for business plans, volumes for buying capital items ... We use it for contract stuff. I mean it’s just there, it’s just being used. (Interview with Director Oncology, Central Health, September 1996)

Resisting or reconstructing the concepts and practices associated with the casemix information meant challenging the whole information system. This was a difficult undertaking given its technical complexity and the organisational resources tied up with it (Knights and Murray, 1994). The casemix system was presented as necessary for securing reimbursement from the local purchasing authority. In this way, the existence of the casemix information system was linked to the existence of the organisation, making it correspondingly more difficult to argue against the system (Latour, 1987).

**Conclusion**

The clinical leadership ordering strategy attempted at Central Health drew on multiple discourses and practices, and involved an attempt to construct a heterogeneous network of ordering. This network was simultaneously discursive, relational and material. The power effects of this discursive strategy included defining both the perceived problem and the
solution in managerial and economic terms. This acted to undermine medical or professional perspectives while mobilising an understanding of organisational reality grounded in economic notions of value and commodity.

The discursive ordering strategy involved the attempted constitution of clinicians as subjects of management discourse. For example, clinicians were constituted as utilisation managers in reviewing and regulating their own clinical practice using casemix information, or as clinician managers in the way that casemix information was combined with specific organisational forms to produce more defined accountabilities for clinicians. However, the constitution of senior clinicians as clinician managers remained stable only to the extent that the uncertain and fragile network built around the notion of clinical leadership. Actors such as clinical unit directors can be viewed as relational effects, constituted in their relationships with other actors whether medical colleagues, managers, the purchasing authority or information technology.

Information technology was enlisted in support of the clinical leadership strategy. For example, the casemix information system was used both to define organisational entities and to render their work visible and susceptible to management intervention. The interdependency of the casemix information system and the clinical units within which it was used and which it helped structure, did help to promulgate the new management and economic discourse in health care and to produce more defined accountabilities for clinicians.

As an organisational form, clinical units have the potential to translate and reconcile the disparate interests of management in curtailing clinical autonomy and clinicians in maintaining their autonomy. From the clinicians’ point of view, the involvement of senior clinicians in the management of clinical units may offer a way to protect their clinical freedom. From a managerial perspective, clinical units appear as autonomous business units that provide a vehicle for the incorporation of medical professionals into management roles, but subject to centrally controlled constraints: “The imposition of a form of managerialism clothed in the rhetoric of consensus and collaboration, but practising the techniques of tighter control and accountability” (Reed and Anthony 1993, p. 192).

In complex and uncertain environments such as hospitals, organisation reflects the mediation of professional roles and autonomy with the pressures introduced by market rationality, managerial control and technological change. In the long term, the effectiveness of strategies such as that described in this paper will depend on the extent to which the roles created under clinical leadership are accepted by organisational participants, and the consequent renegotiation of the boundaries between management and other expert disciplines.

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1 An actor, in the (semiotic) sense used here, is something that acts or to which activity is granted by others. That is, an actor is granted to be the source of an action, regardless of its status as a human or non-human.

2 Of course, if organisation is a performance (Law, 1994; Parker, 1997), then, in a fundamental sense, organisation is change, and the term “organisational change” becomes a tautology. Nevertheless, it is convenient to use the term to reflect a (more or less) deliberate strategy for re-ordering the organisation towards some intentional outcome over a period of time.
3 The Health and Disability Services Act 1993 reformed New Zealand public health providers into commercial entities. The Act included a statutory objective for the new Crown Health Enterprises to operate as successful and efficient businesses. At the same time, four Regional Health Authorities were created to act as purchasers of health care, effecting the separation of purchaser and provider roles and allowing the introduction of a managed market in health care.

4 In three clinical units, no senior clinician could be persuaded to become the unit director. Instead, professional managers were left to deal with the perceived mundane role of managing the units. This represented a complete circumvention of the role of clinician manager defined in the clinical leadership.

References


