

Middlesex University Business School
Discussion Paper Series in Human Resource Management No 12

**So far so Good? Or Organisational Behaviour in Healthcare
– the development of a field.**

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Publication of this Keynote address by Middlesex University celebrates the progress of this academic subject and its associated conference since the inception of the first meeting by Professor Mark at Middlesex University in 1998.

KEYNOTE ADDRESS

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at the
6th Organisational Behaviour in Healthcare Conference
held by the University of New South Wales at
the Citigate Central Hotel
Sydney Australia
March 2008*

*This Keynote address that celebrates the progress of this academic subject and its associated community since the inception of the first meeting at Middlesex University in 1998 has continued as an international biennial meeting with associated publications including
a book series from the conferences published by Palgrave Macmillan.*

It is now supported by the Learned Society for Studies in Organizing Healthcare (SHOC) of which Prof Mark is the first Chair and Prof Ferlie the first treasurer; it is a member of the UK Academy of Social Sciences and successfully nominated Prof Ferlie as its first Academician.

Introduction

In 1998 when I set up the first OBHC conference at Middlesex University there was much enthusiasm from a small band of academics, who remain central to this conference today, for such meetings to begin. They were familiar with the trials and tribulations of working through the social science disciplines in the heart of a clinical scientific community, bounded by the privileged research discourse in healthcare that still started and some would say finished with the Randomised Control Trial; indeed it was one of our Canadian colleagues at that first conference in 1998 who commented how refreshing it was to sit in a room and present work without having to explain why she was using qualitative research methods. However, we are grateful to biomedicine for a well developed concern for standards of research enquiry and evidence (albeit of a very different nature) and so the OBHC community is one that also values such standards but within a social science based research approach, rather than the consultancy or guru based approaches that are attractive to other communities.

Some, however, may still ask the questions:

- why should we focus on organisational behaviour in healthcare, and
- what is the field of study that is being explored?
- Why has it become more significant a discipline than say twenty years ago?

In answer to these questions we can say that it reflects wider changes in the field, with a move away from traditional patterns of professional dominance (Friedson 1963) to a more managed regime. This has enabled the organisational and management dimensions of health care to become more evident and therefore in need of study. In addition the expansion of staff often drawn from Social Science disciplines but now working within Business Schools in particular, has expanded the supply side of researchers. The issues they considered like the management of change, getting doctors into management and service improvement are all themes of importance in the field which lend themselves to the Organisational Behaviour perspective.

For those unaware of the text from the original conference, the first meeting considered the research agenda itself (Mark & Dopson 1999) and the need to:

- build on existing knowledge, both theoretical and empirical,

- to understand the nature of research and its methodologies, and
- to understand the complex nature of the issues and what might be termed the problems of linear thinking which have limited both the scientific and managerial/policy perspectives in this domain.

In ten years we may not seem to have come very far, but ten years is a relatively short time in the academic world but a whole decade in healthcare, where individuals, organisations and complete healthcare policies and communities have come and gone, with increasing rapidity in the UK which now also, coincidentally, has adopted forms of devolved government more familiar to our Australian hosts, albeit a good deal smaller in size. This continual disruption and devolution familiar in many other parts of the world as well, results in not only the loss of organizational memory (Kransdorff 2006) but also what our Australian colleague Caddy (Caddy 2001) describes as orphan knowledge where knowledge is forgotten, separated, or isolated within the organisation because of the dislocation of both individuals and organisations. So the fact that we are here today, ten years later, allows us to claim that we do begin to provide some continuity through our meetings and publications; demonstrating not only how the field is evolving over time, but also the tenacity of academic identities when brought together in such networks. In addition, the series of biennial conferences has been linked to the production of a series of book editions by Palgrave so that a cumulative and published knowledge base has been emerging.

Influence

Even from the start of the conferences we have been able to influence developments in the domain of health policy and health research, for example, the first published volume was informative for Sir John Pattison who led the initial development of the UK NHS Service Delivery and Organisations research programme, as a new funding stream for the NHS; although some distinguishing issues exist between what we wish to achieve and what their remit is (Mark 2006). While this NHS development has helpfully supported OB research in English healthcare, in the now devolved Scotland the trajectory has been different remaining under the medical model controlled by the Chief Scientists Office, although this too I understand from my Scottish colleague

Prof. McKee, is about to change, so progress, albeit at different rates for the discipline, is happening across the UK.

Another distinctive contribution which has been afforded by the conference and field of study, is its exploration of issues through what Wenger would no doubt describe as a community of practice (Wenger 2000) marked out particularly by its growing international focus. This is because, as I have said elsewhere,

“healthcare is a generic term for a range of activities carried out between providers and patients where linguistic and interpretative meaning can differ (Rousseau & Fried 2001). The location of health ranges from traditional healers in the developing world to medical consultants practising in the most sophisticated western hospitals. What they have in common is participation in an activity, which requires trust between the parties concerned. Trust in this context is essentially the willingness to make ourselves vulnerable to others (Korczynski M 2000) as part of the reciprocal nature of all trust relationships(Reed 2001) that are integral to the successful practice of healthcare. Where the location differs is the organisational and social (and cultural) context and infrastructure that surround such encounters. The behaviour in these different environmental contexts will not be the same and it is important to be aware of how these differences will shape assumptions about what matters and what can be applied elsewhere.”(Mark 2006)

Definitions

So is it now time to draw even more distinctive descriptors and boundaries around the notion of healthcare organisation even though it might seem something of an oxymoron?

The notion of organisation rather than say management or policy is significant because it encapsulates both formal and informal activities at a local, national and international level and within both a developed and developing world context, and does not confine its understanding to either the managerial or policy process. Grey suggests (Grey 2005) that organisation is not a subset of management but rather the other way around, placing it at the centre of our understanding of the social, ethical and political dilemmas of the twenty-first century. It is about what happens, not just about what people want or are trying to make happen. Furthermore the issues are as much about those who use the organisations, as those who work within them, but this

aspect may not so far have had sufficient impact on the research presented to date within our community. In healthcare a number of research agendas around patient choice (Fotaki 2006), the experience of emotion in traversing healthcare organisations (Mark 2005) or the impact of continual changes to the organisation (Fulop & Allen 2001) (Buchanan 2003) exemplify this increasing importance, not just to those managing it, but also to those using services, and it is within this broader context that developing the field for the future becomes even more relevant.

So what makes us different from other parts of the social science community working in this field and what can we do in the next ten years and beyond to take the issues forward?

Anchoring the disciplinary interest theoretically before 1998 reveals a scattered and varied literature motivated by to the two drivers of academic curiosity and policy/management fashion (Benders & Van Veen 2001) where the focus moves around disciplines sometimes enabling an interdisciplinary way of thinking (Schien 2006), so for example, studies are found in management, psychology, anthropology, sociology and accountancy to name but a few. This location of work in a variety of disciplines is however a strength, rather than a weakness because it suggests no method is superior to others but reflects only the scientific culture or subculture it sits within (Schien 2006). What we have sought to do through this conference is thus to develop a sense of shared identity between those involved in understanding healthcare organisations, providing both a focus for understanding the issues relevant to our purpose.

History

The historical interest in organisational behaviour in healthcare can be traced back as far as ancient Greece (Wood & Ferlie 2003); in the 19th century the extensive writings of Florence Nightingale on the organisation of hospitals and healthcare are also influential (Nightingale 1863), but perhaps the most significant starting points for our work in the UK and beyond can be found from the Tavistock Institute, for example through the work of Elizabeth Menzies on the meaning of nursing work in a hospital setting (Menzies 1960), and such perspectives still continue to bring insights to the field (Hinshelwood & Skogstad 2000) today. In a wider context, the work of Friedson

particularly *The Hospital in Modern Society* (Friedson 1963) set many issues on the agenda that we still study today. Furthermore, the work of the Chicago School remains relevant, for example Goffman (Goffman 1959), identified elements we now interpret through the new lens of the emotional labour process (Hochschild 1983) that has been so influential in understanding nursing work (Smith & Gray 2001); this insight now also extends to the work of doctors (Larson & Yao 2005). It is furthermore in respect of doctors that the Chicago School also produced seminal works such as Becker's study (Geer et al. 1976) "Boys in White" about the culture of medical education, especially relevant to the subject matter of our conference here in Sydney. It is notable that while such work retains so much influence and affection in the eyes of the UK OBHC community it has been rather eclipsed in its home country of the USA, where more positivistic approaches have more recently colonised the world of health services research. The shortage and some would argue demise of such ethnographic methods is influenced itself by resource constraints, I remember being told relatively recently that a well respected research funder in the UK asked for the costing of a Boys in White type ethnographic study, only to discover that its current costs ruled it out as a project. But ethnography is re-emerging in ways which some of our European colleagues suggest will be of use to this community (Kamsteeg & Wels 2004) through an anthropological model of organization studies in which culture, identity and power are the key concepts.

Which organisation, which theory?

So why is it necessary to separate healthcare from other types of organisation? Well it is not, but there are advantages to having a separate forum in which the complexities and peculiar challenges in healthcare organisation can be addressed, not least because both healthcare and organisations can have a profound effect on individual well being, for good or ill, and in combination the effects, when negative, can be devastating; as evidence from the Public Enquiry in to the tragic events at Bristol Royal Infirmary Paediatric Cardiology department in the UK showed us (Kennedy 2001).

In more specific terms the field of organisational behaviour is itself contested from within the discipline at many levels, whether from the Critical Theory perspectives (Mills, Simmons, & Helms Mills 2004) begun by Coopers Open Field

article in *Human Relations* published in 1976 (Cooper 1976), structuralist views (Lounsbury & Ventresca 2003) or poststructuralist and postmodern analysis (Jackson & Carter 2006), to name just some strands now engaged in the debate from an organisational theory perspective (Clegg et al. 2006). The influence of ideas from institutional theory (Davis & Marquis 2005; Reay & Hinings 2005) are also currently fashionable within healthcare, but it is however not my intention to be comprehensive here, but to draw out the point that these theoretical debates of both root and purpose reflect more of a European social theory perspective, rather than the more solutions focused approach often found in the American literature. These solutions focussed approaches have sought, especially recently, to enable management practice through a focus on problems such as managing change (Grey 2003) rather than on the paradigms (Davis & Marquis 2005) or ways of seeing that are involved. While such diversity adds strength to the debate about what matters, it must be reiterated that our conference, from the outset, reflects the ebb and flow of debate rather than a linear progress towards definitions in the field of organisation studies which Schien himself considers to be in a “pre Darwinian state of development” (Schien 2006). This increasingly also separates it from other research groups in the UK that seek to enable the management and delivery of healthcare; but that is not to say we do not have an interest in practice, but it is not our starting point. Indeed the gap between theory and practice cannot become a chasm of misunderstanding into which patients will ultimately fall, so relationships between the two are critical to both, and will have a continuing voice in our community. This diversity of perspectives between understanding and enabling is reflected in the content of the conference subject matter to date. It is of itself part of the debate and creative tension of this field, and helps to define it as an appropriate unit of analysis (Davis & Marquis 2005). The conferences so far have considered:

- the research agenda (Mark & Dopson 1999) held at Middlesex University in 1998
- the future boundaries to the discipline in particular new ways of seeing, working and understanding the field (Ashburner 2001), held at Keele University in 2000
- leadership, who does it and interprets it, what it looks like in successful healthcare organisations, can we transfer it, what will it look like in future (Dopson & Mark 2003) held at Oxford University in 2002

- Innovation, considering the role of research and practice in bringing about change, and interestingly, for this Canadian based conference, the evidence base for management action and change across the many boundaries in healthcare (Casebeer, Harrison, & Mark 2006) held by the University of Calgary in 2004
- power the handling of organizational politics, power and change as a core aspect of effective reorganizations in this politically charged arena (McKee, Ferlie, & Hyde 2008) held at Aberdeen University in 2006

So far, in this biennial conference, we have considered matters of concern that cross both the traditional and emerging perspectives in organisational behaviour, now reflected in the more innovative textbooks for the field (Ackroyd & Thompson 1999), (Fineman, Sims, & Gabriel 2005; Grey 2005) and it is entirely appropriate that here in Sydney we consider climate and culture, in a country at the apex of what might be described as these new and old world perspectives. As a focus for emerging ideas this dynamic tension within Antipodean research will no doubt produce many new and creative ideas to inform our community, as the work of our host Professor Braithwaite and his colleagues already shows us (McKee, Ferlie, & Hyde 2008) particularly in respect of safety cultures. Furthermore differentiating climate and culture itself reveals a just position between the prominence of qualitative perspectives in the old and the regard for quantitative approaches in the new world views. This is because organisational culture, derived as it is from anthropology, is studied in this qualitative way while organisational climate takes a more quantitative approach (Scott, Mannion, & Marshall 2003). It is in essence more fleeting as the metaphorical use of the term implies, so data capture perhaps needs to be more immediate, but may be less informative, or to put it another way the qualitative approach compared to the quantitative approach, as Sweeney and Kernick (Sweeney & Kernick 2002) suggest, allows us to be vaguely right rather than precisely wrong because, as they go on to say, analytical and predictive power is often best employed by stepping back and looking at the overall context. This is because the change target is not always obvious (Schien 2006) and, in biomedical terms, may be a symptom rather than a cause. In my own current research as part of an eight country European study on the quality of working life across the four organisational types of hospitals, banks, supermarkets and high tech industries www.projectquality.org , we can see the differences and

similarities between both methods and context in these separate environments as we seek to explore the changing experiences. Indeed the development of the OBHC field, as Ferlie et al state in their opening chapter to the book from the last conference (McKee, Ferlie, & Hyde 2008), means that “the task for researchers may be to question conventional models of evaluation and to uncover the empirical messiness of organisational transformation and in so doing to provide powerful new images and analogies for the policy system as well as surprising insights. Qualitative forms of evaluation in particular may provoke creative thought.”

Moreover the power of methods which also capture context is critical for both perspectives (Rousseau & Fried 2001), a point on which many of us agree (Mark 2006) (Schien 2006) (McKee, Ferlie, & Hyde 2008) and is, as Harding suggests, always in a process of becoming, for both those who are the subject of, and those who undertake, the research. As she concludes (Harding 2007) the organization I am ‘in’ is at the same time ‘in’ me: there is no inside and no outside, this observation derived as it is from her work in healthcare research, is peculiarly relevant to such perspectives, but also highlights the emergence of the role of the researcher as a discourse within the wider debate (Mark 2006) on research in organisations. This raises issues about the background of the researchers themselves who will undertake the interpretation of data (Etherington 2005). This also needs to be made more explicit (Bartunek & Seo 2002) as part of contextual information for the process of research, as our historical understanding of key researchers like Lewin and indeed Schien himself has shown (Cooke 1999; Schien 2006).

New Directions

Besides the development of the conference itself, with associated publications which now include edited special edition journals, (Fitzgerald, Mark, & McKee 2007) there are other strategies, of which you may be aware, to ensure the field develops a distinctive voice. My co author Ewan Ferlie has been instrumental in this, with his proposal that we should set up a learned society, following our fourth conference in Canada. This came into being at its inaugural meeting on 24th November 2004 and SHOC, the Society for Studies in Organizing Healthcare now has oversight of this conference, but furthermore as its name also suggests, is, like its field of study, in a constant state of surprised becoming. We believe that it occupies a special niche as a learned society of OB scholars that are both connected to the health care field but to a

certain extent also detached observers. It also takes a particular interest in organisational forms of research, as opposed to some other Health Services Research societies which are by their very nature different in focus.

The purpose of SHOC established at its inaugural meeting is:

- the promotion of excellence and encouragement of advancement in the organisation of healthcare through research, education and service to the community

- to support and encourage the advancement through collaboration and when appropriate representative discussions and advice to governments and other communities at both political and administrative levels ,nationally and internationally

- to develop and disseminate theory and practice in organising healthcare through the provision of conferences seminars and associated publications, both nationally and internationally

- to comment on national needs and encourage international cooperation in the development and practise of organising for healthcare

- to enhance the organisation of healthcare through the recognition and celebration of outstanding contributions

- in pursuit of the above to bring together such people and resources as are needed to create sustain and develop the society to achieve its purpose

It is now also part of the British Academy of Social Sciences and able to contribute to wider consultations by government of this grouping of the key learned societies within the UK Social Sciences.

Our intention is also to enable where at all possible the sharing of information about conferences and publications and to encourage local meetings to hear about leading research and practice. These we are endeavouring to capture electronically to ensure

they can be available to SHOC members which ever part of the world they are in, because while established in the UK our interests are relentlessly international.

Progress

So what of our progress as far as content is concerned?

In considering issues for research in this area as set out in our first book in 1999(Mark & Dopson 1999) there is some indication that progress is being made as the following examples demonstrate, but we now also need to establish what new areas we might want to add to this:

Collaboration - in both undertaking research, and as a research area in healthcare - recent research on the development of organisational collaboratives to ensure quality in healthcare, reveals some progress is indicated at an international level (Ovretveit et al. 2002).

Behaviour - in aligning what people do as well as what they say they do is more problematic, but the increasing interest in emotion as well as cognition as a basis for action is now being addressed in healthcare.

Consumers - patients in particular increasingly feature as integral to effective research in healthcare (Coulter 2003), and the wider community is now being researched and developed as part of this engagement(Pickin et al. 2003)

Multiple interpretations and meta analysis - there is some progress in the use of multiple interpretations within research(Buchanan 2003) but this will reduce the probability of making a meta-analysis of the field because it is less possible or indeed appropriate to compare like with like studies (Ferlie 2001).

Context - new modes of working are being encouraged(Department of Health 2000) but this must be seen within the historical and hierarchical structuring of knowledge in health. These are shown to reproduce barriers to implementation because of professional and organisational patterns of behaviour, which are hard to break, as a recent meta analysis of the nurse practitioner role demonstrates (Jones 2005)

Interrelationships - the interrelationships between policy issues as a matter of concern is now highlighted in some areas of health care research, for example the UK Economic and Scientific Research Council Report (ESRC) 'Telemedicine & the Future Patient: Risk, Governance and Innovation', programme demonstrated this within the Innovative Health Technologies Programme.

Emergent outcomes - the great difficulty in reversing the hypothetical view of research questions is itself problematic, but continues to be reinforced by cultural artefacts, such as journal and conference submission proformas, which continue to constrain those submitting into such formats. The move away from this is how ever beginning, and is taken more seriously now it is nested within ideas and concepts from complexity science (Kernick D. 2002)

Longitudinal studies - these are still largely confined in health to clinical conditions such as cancer, or professional groups such as doctors, because of the associated economic incentives to find out what is happening (Moss et al. 2004) but more needs to be done if the political incentives to prevent this can be avoided.

Conflicting agendas - this is part of the complexity problem, but is not really addressed conceptually at present but only through incentives provided within good network relationships between particular parties.

Poverty in pragmatism - what works in the short term is not carried through to the long term because it may not be in the political interests of funding bodies to see the long term, and tracking across organisations and time requires international collaboration with secure investment in projects.

International collaboration - improvements are happening as some of the previously cited studies and conferences demonstrate. More could be done and this may be facilitated by increasing use of communications technology.

Futures

So where are we now and where do we need to go?

We have established

- 1 a biennial conference
- 2 a productive series of books creating a cumulative knowledge base
- 3 a learned society
- 4 membership of the Academy – so we may be consulted on health services research now;
and distinctively we can be separated from other bodies because we are less managerialist and more organisationally based

As to the future, that is for this community to determine, but I suggest what we must focus on is the need to provide for discussion and debate about any health organisation, anywhere, that is involved in facilitating the interaction of patients and providers of healthcare. Integral to this is an understanding of how cultural context affects this interaction, so it is timely that our hosts in Sydney suggested this subject for the conference in 2008.

Concluding remarks

Ten years is a short time to consider progress, but I think we have made a credible start, and a biennial approach has enabled a sustainable development of the community and its work. This is further supported by the announcement today that Palgrave have designated the books from the conference into an academic series that will, I am delighted to say, have me as its first series editor.

We have much to do in this conference in Sydney, but perhaps not so far the retrospective gaze of Edgar Schien (Schien 2006), as the academic father of organisational culture, who has been able to review his own formidable work over 5 decades in his 2006 Organisational Studies article entitled *From Brainwashing to Organizational Therapy: A Conceptual and Empirical Journey in Search of 'Systemic' Health and a General Model of Change Dynamics. A Drama in Five Acts*. We are in these terms at the start of the second act upon which I think we should now raise the curtain and let the play begin.

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