

CHAPTER ONE

AUSTRALIAN GOVERNMENT POLICY AND THE HEALTH SECTOR

Whenever a sudden, striking shift occurs in Government philosophy and policy, it may be expected that far-reaching changes will result. Arguably, the institutions, and the people in them, who are immediately subject to such changes may be profoundly, disturbingly and negatively affected. This thesis aims to examine one such immense shift in Australian Federal and Victorian State philosophy and policy in the health system, and the effects of this change on two, culturally diverse hospitals that were forced to amalgamate. Of particular interest were the survivors of this process, and their reactions not only to the changes per se, but to the ways in which the change process was managed, both by the Governments, Federal and State, and the hospitals themselves.

The history of the health system in Australia is very complex, at Federal and State levels. It was felt, therefore, that to enable the reader to best understand the reactions of the survivors of the hospital amalgamation, it was necessary to go into considerable detail. At the risk of presenting too much detail, this chapter is structured as follows. It begins with an account of the early philosophy behind the provision of health care in Australia, and the manner in which hospitals were established as a result. Next, the shift in philosophy and policy by the Federal Government to economic rationalism is explained, and the Government's reform agenda is exposed. As the hospitals at the centre of the amalgamation being studied are

located in the State of Victoria, the chapter continues with an exploration of the health system in that State, and the reform agenda there that resulted in the forced amalgamation of the Alpha and Beta Hospitals.

Historically, Australian governments have held the view that "private markets will not ensure that those who are economically or socially disadvantaged have adequate access to affordable, high-quality health care" (Podger & Hagan, 2000, p.116). This has meant that some form of government intervention, in the form of public bureaucracy, was seen as essential in systems such as that of health, where access to service supersedes the ability to pay. Public financing of essential health care was considered, therefore, to be justified, in that it was seen to alleviate the poverty that might result from having to pay unexpected, large health bills. This philosophy of universal coverage and free care is the rationale underpinning major government programs such as Medicare, even though, as Podger & Hagan (2000) point out, a good proportion of the population might be able to pay for basic health care.

Indeed, for the first half of the twentieth century Australia had been the "social lighthouse" of the world. In comparison, Sweden was seen as Europe's "poorhouse fortress" (Pusey, 1991, p. 1). As Pusey (1991) pointed out, the benefits of a nation that was "born modern" lay in the knowledge and conviction that the State would be the most likely protector of individual rights against other agencies of social coercion, as "the public sector is concerned about the public good based on beliefs in rights and a redistributive ethos, rather than being purely profit-driven" (Hancock, 1999, p.60).

The philosophy of universal coverage and free care on which Australia's health system was founded had a significant influence, as one might expect, on the way in which hospitals in particular, developed. Community health centres, patient transport, and psychiatric services were also influenced by this philosophy, of course, but the focus of this research is on hospitals, and two in particular.

Australian hospitals began in the nineteenth century when they were established for the treatment of convicts and the military. Historically, major public hospitals provided acute care, free of charge to the indigent, and were primarily funded through donations with a supplementary contribution from government, while doctors provided their services to indigent patients in an honorary capacity. Most public hospitals developed as charitable institutions, managed by autonomous boards of management. The members of these boards included local philanthropists, doctors and community business people. As the financing of the hospitals became more onerous, however, they turned more and more to governments for their upkeep. The State began to play a major role in provision of health care between the two World Wars as demand for health services escalated (Bloom, 2000). Still seen primarily as a source of charitable health care for the indigent, public hospitals multiplied. In response, State governments established separate public (State-subsidized) and private (paid directly by the patients) wards in public hospitals. Not unexpectedly, as the government increased its financial support to hospitals, it required more accountability for their management and expenditure of funds.

Hospitals have provided a comprehensive range of services. This range exceeds that which has been available in the private sector, although some larger private hospitals have offered a similar range of services. As a rule, however, the public hospitals have provided services for the more complex medical and surgical cases, in addition to research and teaching, while private hospitals have tended to treat more straightforward cases. Historically, moreover, the public hospital system has provided a mix of both general hospitals and more specialized hospitals for the treatment of psychiatric illness, obstetrics, and paediatrics. This has resulted in the development of separate hospital establishments for these specific areas of medicine. Since the 1990s however, health planning philosophy has not generally supported the creation of new specific purpose hospitals dedicated to groups of patients with particular medical needs. Furthermore, private hospitals have greatly increased their sophistication and level of clinical services, not only offering "a real alternative to public hospitals but also functioning as an essential safety valve in the demand for hospital admission for procedural services" (Foley, 2000, p. 112).

Financing of health care has been one of the most pressing issues for health planners and health economists. Because responsibilities for health funding and provision have been split largely between the Commonwealth and the States (with local communities playing a part in public and environmental health), each has influenced the structure, financing and priorities of the health system. Because different political parties can rule at the same time at Commonwealth and State levels within Australia, a dynamic tension has often existed within the health system (Bloom, 2000). Such had been the situation in the Australian health care system for the best part of the twentieth century.

The late 1980s, however, brought a sudden shift in thinking in the public sector – a change in the “dominant discourse” (Hancock, 1999, p. 42), from universal coverage and free care, to economic rationalism. Arguably, this change had been foreshadowed by the Jamison Commission, established by the Fraser government in 1979 to recommend changes in the Commonwealth’s funding of public hospitals and in health insurance. The Commission drew attention to the apparent lack of efficiency in the administration of hospitals and the absence of adequate statistical and management information systems (Commission of Inquiry into the Efficiency and Administration of Hospitals, 1981). Comparison of the efficiency of different hospitals was impossible to make, according to this Commission, because of the inability to measure in any meaningful way the outputs of hospitals and the outcomes of treatment (Palmer & Short, 2000). As an outcome of the Commission’s report, the Commonwealth Government decided to replace the existing cost-sharing agreements with a system of identified health grants. At the time this marked the end of free hospitalization as an option for all patients, except those who met the Commonwealth’s criteria for having special needs.

The change in government thinking could reasonably be described as dramatic. Nevertheless, it was a change that appealed to Australian governments of different political persuasions, at Commonwealth and State levels, as they acted to reduce both the National and State debt. Nor, it should be noted, was Australia alone in this, as similar thinking occurred in New Zealand, Canada, the United Kingdom and the United States of America. In fact, economic rationalism was first adopted by conservative governments in the United States of America and the United Kingdom from the early 1980s as a radical way of reducing public sector costs; policy analysis followed. At this stage much of this analysis

in Australia was negative and was concerned to "protect the role of the state as 'interventionist and protective' to ensure a decent way of life for its citizens" (Gardner, 1997, p. 3).

Economic Rationalism

The discourse of economic rationalism understands fairness or "equity" as a concept that is evaluated not only in accordance with the energy (including knowledge, ability, and time) that people have invested in order to realize an outcome, but also in accordance with the "value" that society has placed on that energy. This societal recognition of value is illustrated by the *market value* of a commodity, which broadly refers to the amount that "consumers" are prepared to pay for it. This in turn, will be a function of supply and demand.

Pusey (1991) charted the commitment to economic rationalist ideology by senior bureaucrats in key federal government departments in Australia in the late 1980s and early 1990s. Pusey contended that within the Australian context, the triumph of economic rationalism pointed to a weakness of culture and civil society which was etched into the images of contemporary Australia, and informed much, or most, of what was done in Canberra. The State apparatus was then caught within projections of reality that gave primacy to "the economy", second place to the political order, and third place to the social order. It seemed as if, since the 1970s, reality had been turned upside down and society recast as the object of politics rather than the subject of politics. Further, society was represented as an idealized opponent of "the economy." "The tail that is the economy wags

the dog that is society and this inversion forced consideration of how and in what respects culture and identity can have any 'structure forming' effects" (Pusey, 1991, p. 10). Other researchers such as Hancock (1999) have also noted "the dominance of this paradigm to government at all levels, and its identification with neoliberal forms of governance" (p. 57).

Economic rationalism has been conceptualized as governing through the regulation of individual citizen's choices. This is accomplished through the dismantling of State provision of health, housing, and education, and replacing this with individuals providing for their own needs by purchasing goods in a competitive market. The role of the State is seen as minimalist, regulating through contractualism and corporate management models and working through markets. A safety-net is provided by the government for particular groups in acute need. However, this welfare is self-provided (or based on self/community/government partnerships) thus encouraging individualism and independence as opposed to welfare models, where risk is carried by the State and supported by the collectivity (Hancock, 1999).

Economic rationalism embraces the assumption of market value. This assumption, "considered in conjunction with the efficient allocation of resources throughout society, implies that people, or organizations, will be differentially rewarded according to their ability to advance the goal of economic productivity" (Lasky, 1996, p. 65). Enhanced knowledge, skills and abilities which are used to maximize production deserve greater rewards than those that do not. Moreover, one could add that the end which can produce the highest return for the use of a given means should be assigned that means, so that scarce resources are deployed in the most efficient and effective way. In the case of the health

system, this means that the hospital that reduces its waiting list and also expands the number of patients it treats, should receive a greater slice of available funding.

When taken at the level of the individual, the stock of acquired talents, skills and knowledge which can enhance a worker's earning power in the labour market is referred to as *human capital*. Human capital theorists attempt to explain existing relativities in the distribution of wealth in terms of education and training. The argument is that wage differentials are the reward for the personal investments individuals make in their human capital. "In human capital theory, the "investment" commonly discussed is the education and training that individuals choose to undertake beyond their compulsory school years" (Lasky, 1996, p.70). The costs are incurred now, and the returns are expected later. The major cost to the individual is that of immediate income forgone if the individual undertakes unpaid full-time training, or the possible postponement of salary increases or promotion if the individual studies part-time. The returns take the form of greater "earnings" over a lifetime, and an increase in the individual's stock of knowledge.

Society, however, also incurs costs and receives a return. In the case in point, costs include the direct costs of operating institutions such as hospitals, the cost of staff salaries, and research and other grants made by governments to such institutions. The return is the economic benefit that arises from the adjustment to structural and technological change, and that increases productivity to society as a whole. The best results for organizations, and the Australian nation, it has been argued, will flow from the greater labour flexibility and adaptability that can be achieved. The best results for patients will include easy to

access and appropriate facilities when needed; a high standard of care; affordable treatment and suitable after-care if required.

Also underlying economic rationalism is "a commitment to rational or social choice theory" (Hancock, 1999, p. 57). Rational choice theory assumes that humans are motivated in their political and economic behaviour to maximize self-gain. Perceived as a liberal economic unit, the individual is unitary, calculating, egoistic, and motivated solely by the economic end of accumulating wealth by means of profit maximization. Moreover, rational theory assumes that managers and politicians seek also to maximize benefits to themselves and/or their departments (in terms of budgets, votes or personal remuneration, or power) through self-seeking policy advice and decision-making - hence the drive to separate government policy decision-making from service-delivery functions (the latter are often contracted out) in the public sector (Hancock, 1999).

Where the specific characteristics of health in relation to the operation of free market principles is concerned, the argument, according to market theory, is that consumer choice and competition result in efficiencies. In the health area, however, we must take note of the important differences that prevail (Hancock, 1999). Providers (doctors and health care professionals), rather than consumers, determine the supply for health services; relationships between providers and consumers are less direct, and the funder (government in the public sector or insurer in the private sector) is rarely the user or the provider; consumers lack expert knowledge and are weak bargainers in the market place, and are unable to judge for themselves the quality of hospital care prior to admission, or the safety of a surgeon's skills. Health needs are often not elective or subject to choice (in the same

way that buying a new television might be). There may be no choice of facility or provider in rural or remote areas or, indeed, in metropolitan hospitals with no reserve casualty or ward capacity, and where ambulance services and doctors may need to call on five hospitals to find a vacancy. Moreover, customer's willingness to pay is not so relevant as it is in other areas of consumption, given set fees (within ranges). Finally, health has, over time, been viewed as "a system committed to access to services according to need, rather than ability to pay" (Hancock, 1999, p. 61), and as a social or public good, and indeed, as a right, related to collective responsibility, rather than as a commodity dependent on the individual's ability to pay. It was these commitments to universal access to available health care resources that helped to shape the NHS in Britain and Medicare in Australia. Since the late 1980s, however, governments have become increasingly non-interventionist.

Criticisms of Economic Rationalism

Hancock (1999) citing Hindess (1988), and Self (1993), draws attention to criticism of this non-interventionist philosophy on the grounds that it assumes that human behaviour is driven by narrow self-interest and abstraction from reality. Criticism of the theory extends to its limited predictive power, its inattentiveness to contextual factors, its lack of grounding in empirical observations, its failure to deliver on promised efficiency and accountability gains, and its inability to explain inconsistencies in behaviour, such as when voters back parties, or bureaucrats support decisions, that put in place policies from which they will not personally gain.

Herbert Simon (1957, cited in Lasky, 1996), in his book *Administrative Behaviour*, was an early critic of the rational economists' view of man. Simon suggested that there is a difference between how economists describe human decision-making behaviour and the

realities of that behaviour. Simon distinguished between an "objective reality" and a "subjective reality". A decision is "objectively" rational if in fact it is the correct behaviour for maximizing given values in a given situation. It is "subjectively" rational if it maximizes attainment relative to the actual knowledge of the subject. "Objective reality" is the only reality considered by the economist. Decision-making of this kind - the comparison and assessment of options against their economic consequences - considers information and choice to be necessary conditions for rational behaviour. Reforms are directed at increasing the level and quality of competition, such as through market deregulation (backed up by anti-monopoly laws) and keeping the public fully informed. Rationality is presumed to be imperfect when there is no competition on price or type of goods or services on offer, so restricting choice, or when some people are denied the choices other people have, often because they have limited access to the available information. Economic and health reforms are consequently directed at eliminating these "barriers" to competition and rational decision-making. "Subjective reality" refers to the way that decision makers perceive the choices that confront them, and to the kind of decisions that might not be so much consistent with a completely impartial and objective assessment, as "consistent with the values, the alternatives, and the information which [the individual] weighed in reaching it. It thus recognizes the fact of human imperfection" (Lasky, 1996, p. 93).

Simon (1957) saw rational-economic man as an unattainable idea. It was not possible, he said, for decision makers to have full knowledge of all the conceivable alternatives and their consequences. There is never enough time for the hospital CEO, pressed to make quick decisions, to identify all the options, and there are too many things that remain uncertain. Moreover, the complexity of the environment, as in the case of health for

example, is such that the decision-maker typically constructs a "simplified" model of the real situation to reduce the situation to a level at which he, or she, can make a decision, within the limitations imposed by his or her thinking capabilities or knowledge. Finally, people do not typically approach decision situations in a purely neutral or objective frame of mind. Rather, they bring pre-formed beliefs and values to the situation which predispose them towards particular choices. These beliefs and values might have been influenced by personality, or, more likely, by social experience and by exposure to a systematic socialization process. In the case of health, life-long exposure to a belief in universal coverage and free care would, arguably, predispose people needing care, particularly if that care is urgent, to go to their nearest health facility, without necessarily knowing whether the facility could actually provide the required service, for example.

By emphasizing the free hand of market mechanism, and the catchcry "let the market decide", economic rationalist economists perceive the market as being outside human influence. Further, they advance the idea that market principles will ensure efficient management, resource allocation and consumer choice. Hancock (1999) noted Pusey's (1993) observation that "economic rationalism is a doctrine that says markets and prices are the only reliable means of setting value on anything", thus inferring that "markets and money can always, at least in principle, deliver better outcomes than states and bureaucracies" (Hancock, 1999, p. 59). It is a doctrine that advances the market as superior to government bureaucracies as a principle of organization. Stretton and Orton (1994, cited in Hancock, 1999) however, questioned the extent to which market relations are, as claimed, more free, fair and efficient than government bureaucracy.

Other critics of the economic rationalist emphasis on the "invisible" hand of the market, such as Heilbroner (1990); Pusey (1991); Emy (1993) and Kelsey (1995, all cited in

Hancock, 1999) have included issues in their thinking such as the narrow economic focus which invalidates social and moral concerns, the negation of the political role of market economics, and the inclination towards individualist rather than collectivist solutions to social issues and problems. By oversimplifying the social dynamics of market societies says Emy (1993, cited in Hancock, 1999), they (the economic rationalists) run the risk of recommending policies which do not contribute to the long-run viability of society as a whole. Similarly, Self (1993, cited in Hancock, 1999), in his analysis and critique of rational choice theory and dominant market ideology in public policy, proposed a left-liberal agenda, where concerns of citizenship and democracy replaced the dominance of rational choice theory.

Scott (1996, cited in Hancock, 1999) argued that free markets were politically constituted social organizations. Meanwhile, differences in the essence of the private and public sectors invalidated the unquestioning application of private sector principles and practices and free-market assumptions to "social" goods, or to institutions or organizations that do not just produce goods or services, but must also look to the public interest.

Like much else in social and economic policy, over time the debate about health policy has become more sophisticated and internationalized (Swerissen & Duckett, 1997). International ideas, principally from Europe and the United States, about the funding, planning and management of health systems were intensely scrutinized by the Australian Commonwealth Government from about 1993. "Health care reform [was] in fashion" (Hall & Viney, 2000, p. 50).

Mooney (1998) reminds us that "whatever health services are about they are about health" (p. 12). He remarked that there was no agreement about the extent to which health services are about maximizing health (the most commonly cited efficiency goal of health care) or maximizing social benefits more generally (with health still dominating but not monopolizing), and the extent they are about equity and fairness in the way resources are allocated. This tension between efficiency and equity is one with which all health services have to grapple, and is at the base of the wide-ranging debate in Australia about the directions its health system should take. It is an issue that underlines much of the controversy surrounding funding arrangements in health care. Questions of competition, for example, through purchaser-provider splits or case-mix funding arrangements for the payment of hospitals (discussed in more detail below), how to pay general practitioners, and many other key issues of health policy, cannot be moved forward without consideration of this efficiency versus equity trade-off. In stark contrast is the "new right" thinking which promotes individual responsibility for health care in a system based on private sector competition rather than national publicly funded schemes, and framed in terms of a mix of individual consumer choice and responsibility. Such arguments, however, overlook structural barriers to the individual's ability to exercise choice and consumer sovereignty.

Several of these have been mentioned above, including, for example, the qualitative difference between the purchase of health needs (which may not be elective or subject to choice) and the purchase of goods such as televisions, which are. Then again, as Hancock (1999, p.61) noted, "there is no definite superiority of either public or private enterprise for the provision of goods and services".

The Reform Agenda

Australia's health system has evolved slowly. Responsibility for ensuring access to health care services has continued to be split among Commonwealth, State, and local governments. The non-government sector accounts for just under a third of total health-care expenditure. The blend of public and private, and Commonwealth and State which had, so far, characterized the Australian health care system, is nowhere more evident than in arrangements for the provision and financing of hospitals. State governments establish, regulate and fund "public hospitals" which provide both inpatient and ambulatory care. State governments also regulate private hospitals which have been established by private entrepreneurs, religious orders or bodies, and other not-for-profit organizations such as community hospitals. Medicare, the current taxation-based system of universal health coverage and pharmaceutical benefits, was introduced by the Commonwealth Hawke Labour government in 1984. It insured that all Australians were able to be treated without charge, in public hospitals. This policy was effected through Commonwealth-State Medicare agreements which defined the formulae by which Commonwealth funds flowed to the State for provision of care to "public patients", and specified the obligations on the States in return for this funding. In 1993/94 Commonwealth funds under the Medicare agreement accounted for about half the running costs of public hospitals (Gardner, 1997). Somjen (2000), in a comparison of the Australian and New Zealand health care systems, pointed out that the health status of Australians improved under Medicare. International

comparison as researched by the World Health Organization (WHO, 1993) readily demonstrated that Australians enjoyed good health and relatively good access to services at a reasonable cost. Mortality and morbidity rates fell, deaths from cardiovascular disease declined, and predicted life-expectancy at birth rose significantly. Not surprisingly, since the introduction of Medicare, Australians increasingly chose to rely on publicly financed health care, resulting in an almost uninterrupted decline in private health insurance enrolment. "Many Australians consider private health insurance superfluous" (Somjen, 2000, p. 57). The visibility of the Medicare levy as a component of income tax has been a further deterrent to private health insurance enrolment. Not unexpectedly then, as private health insurance premiums rose, the proportion of Australians privately insured declined.

Foley (2000) refers to the steeply increasing cost of health insurance premiums, "which have risen at rates well above inflation" (p. 104). Whereas 68 percent of the population had private health coverage in 1982, enrolment had ebbed to a mere 30.5 percent in 1998, and continued to fall. As a result, the proportion of total health care financed by government increased commensurately. Although Medicare continued to be an issue (especially in the elections of 1996), its popularity caused governments to focus on incremental changes to the existing system, rather than devising new models to solve old problems (Somjen, 2000). The Australian health care system as it existed in 1996 was such that, "both finance and provision are dominated by the public sectors, and public and private currently coexist in 'dynamic tension'" (Bloom, 2000, p. 38).

In Australia, the 1990s saw significant shifts in the role of the private sector and private markets in health care funding and the delivery of services (Foley, 2000). The decline in

private health insurance did not result in major adverse impacts on private hospitals. Private hospital growth came largely from attracting the existing insured population away from public hospitals. Those who dropped their insurance were more likely to be lower-risk members who were less likely to require hospitalization. State public hospital systems responded to the rise of private hospitals by attempting to harness private capital through public hospital privatization, and the co-location of private hospitals on the campuses of public ones (Bloom, 2000; Foley; 2000). Further, as a means of expanding public hospital infrastructure, Commonwealth government's war veterans hospitals, for example Hollywood Hospital in Perth in 1999 and Greenslopes Hospital in Brisbane in 1995 were privatized.

The key driver in these developments was the unresolved problem of raising the capital to finance public hospital infrastructure. Under Medicare, the Commonwealth government's payments to the States for public hospitals represented a contribution to operating expenses only. Capital funding had to come from State government sources, in competition with other public works, on an *ad hoc* basis. Under privatization models, however, the private sector financed its own infrastructure development including hospital buildings, and State governments entered into contracts for the private hospital operator to provide public hospital services, where, if the public patient entered a private hospital, the State government paid an agreed percentage of the capital costs of the hospital. As well as tapping private sector sources of capital, these projects were increasingly shifting the operating financial risk from government to the private hospital operator.

Hospital co-locations emerged as the preferred form of private sector participation in hospital care in Australia, however, because "they are perceived to offer the best available combination of risks and benefits" (Bloom, 2000, p. 240). The advantages of co-located facilities were perceived as follows. Co-location projects served to enhance public hospital infrastructure as well as reducing State capital outlays through the sharing of plant and other capital infrastructure with the public hospital. The privately funded facilities also reduced pressure on the public hospital in relation to beds, delivery suites, operating theatres, and other services. The private facilities usually provided an income stream for the public hospital in the form of rent, purchase of diagnostic services, food services, security services, or other support services. For public teaching hospitals in particular, the co-located private hospitals provided for their doctors an opportunity for private practice, thus assisting the public hospital in attracting and retaining doctors and maintaining their full-time presence and commitment to the teaching hospital campus.

Bloom (2000) appraised the risks of growth of co-location for the public sector. "Co-location may disadvantage - or be perceived to disadvantage - the public interest" (p. 242). In Australia, the increasing role of the private sector in health had generated continuing debate and controversy. Probably the greatest immediate risk to the public sector concerned the potential loss of revenue, resulting from the diversion of patients from the public, to the private hospital. The same risk applied to staff members in public hospitals, that is, that they would leave for the private sector. The obvious challenge to the public hospital was to establish the right balance of patients - commercially and clinically, and the right balance of research and teaching.

As mentioned earlier, the Australian public health system rested on a complex set of intergovernmental and community interdependencies, which have both shaped the direction of reform and been shaped by them (Lin & King, 2000). In April, 1995, the Council of Australian Governments (COAG) established a wide-ranging reform agenda focused on improving the efficiency and effectiveness of service delivery by restructuring the planning, organization and funding relationships between Commonwealth and State governments for health and community services. Over the period 1996-98, Australia's Commonwealth, States and Territories negotiated two separate, but linked, public health reform processes.

The first, the introduction of a multilateral National Public Health Partnership (NPHP), between the Commonwealth and all States/Territories, provided a mechanism for greater cooperation and coordination between jurisdictions on public health policy and practice. The second reform was the "broadbanding" of specific purpose payments (SPPs) for the transfer of public health funding from the Commonwealth to the States/Territories into bilateral Public Health Outcome Funding Agreements (PHOFAs). Broadbanding meant pooling specifically allocated program dollars into one block grant. The aim of this reform was to create greater flexibility and administrative efficiency in Commonwealth-State financing arrangements in public health. Lin and King (2000) believed that the parallel introduction of these two reforms changed the context in which Commonwealth-State relations in public health were conducted.

The 1997/1998 financial year saw the first Public Health Outcome Funding Agreements signed between the Commonwealth and the States. Essentially, the agreements transferred the pool of public health funds to each State via one funding agreement. States agreed to

be accountable against a set of outcome indicators. For a number of reasons, the final agreements were negotiated bilaterally, as, tactically, it was easier to conclude negotiation by accommodating variations across jurisdictions. Practically, a bilateral approach could take into account differing needs, priorities, and systems of service delivery. As a matter of reform principle, it was also important to keep financial bickering out of a multilateral policy forum. Therefore, although the broad principles and clauses of each agreement were similar across all States and Territories, they remained bilateral agreements between the Commonwealth and each State, with negotiations occurring State by State (Lin & King, 2000).

Initially COAG concentrated on the development of a relatively uncontroversial, idealized, model for the structure and scope of the system as a whole. COAG agreed that further policy development should occur within three streams of care: general, acute and coordinated (Swerissen & Duckett, 1997). Coordinated care represented a relatively new approach to the funding and organization of services for those with ongoing needs for relatively complex or intensive services which needed to be met by individualized combinations of medical, pharmaceutical, allied health, community support and personal care. It was intended to provide this group with ongoing care, planned and organized with the assistance of a care coordinator, in order to provide a more comprehensive, flexible and efficient range of services tailored to individual needs, while maintaining freedom of choice and fiscal responsibility. At the core of this proposal "was the identification of those needing coordinated care, the development of individualized care plans and the purchase of the required services to implement the plan from a common pool of funds" (Swerissen & Duckett, 1997, p. 40).

Not surprisingly there were significant disputes between the Commonwealth, the States, service providers such as the Royal Australian College of General Practitioners, and consumers, about the development of coordinated care (Swerrisen & Duckett, 1997). The States and the Commonwealth contested the extent to which various funding sources, such as Medicare and the Pharmaceutical Benefits Scheme, were to be included in the funding pool; how the funding pool would be allocated; the scope of the services to be included; the extent to which user and provider participation would be voluntary; and which level of government should be responsible for start-up costs. Providers, like the Royal Australian College of General Practitioners, opposed any loss of autonomy and control over service delivery. Consumers wanted assurances that "participation would be voluntary, Medicare would not be undermined, quality and diversity would be protected and funding would not be reduced" (Swerrisen & Duckett, 1997, p. 40).

Accountability on the hospital side was facilitated by the development of Diagnostic Related Groups (DRGs), "sophisticated hospital output measures" (Donato & Scotton, 1998, p. 31), and casemix measures of hospital activity. Casemix was designed to make it possible to measure State hospital activity and thus hold States accountable for hospital performance (Swerrisen & Duckett, 1997). Casemix, or output – based funding using DRGs, was a way of measuring the mix of inpatients ('cases', hence casemix) a hospital treats, distinguishing a patient who receives a heart transplant, for example, from one who has an appendix removed. "Once patients have been classified into DRGs, a standard price can be assigned to each DRG and hospitals paid on the basis of how many patients in each DRG the hospital treats" (Swerrisen & Duckett, 1997, p. 22). The revisions of the Medicare agreement in 1995 exemplified this trend: "the agreements replaced a measure of

activity based on proportionate change between states of public bed-days by targets for each state of DRG-weighted public separations (the latter being a direct measure of access by public patients in the state). The agreements also included a measure of 'failed' access in terms of the percentage of people in the state who wait longer than is clinically desirable" (Swerissen & Duckett, 1997, p. 41). It was proposed that the next stage of Commonwealth-State negotiations would be to extend the measures of accountability both in terms of range (for example, introduce quality measures) accountability, and specificity (for example, measure at the regional or hospital level, rather than at the State level).

In 1997, the character of the Australian health care system was depicted by Lin and Duckett (1997) as "a mixed system in the way it is financed and organized" (p. 46). This continued to be so at the time when the present research was conducted, specifically, during the time the interviewing was conducted. The public sector was the dominant component, with hospitals funded and managed by government. There existed, however, a small and vocal private hospital and private health insurance industry. While the Commonwealth Government, through Medicare, subsidized medical services directly, it provided funds to the States for the operation of the public sector health care system. Over time, all the Australian States moved to various forms of decentralized management for the public health care system, generally known as regional, or area, authorities. With these organizational and policy shifts, there developed an increasingly politicized and complex system.

THE VICTORIAN PUBLIC HEALTH SYSTEM

The fiscal crises of the 1970s and 1980s in the Australian State of Victoria produced "a virulent critique of the so-called 'command and control' management of the welfare state which had previously served government well [with its emphasis on] central bureaucratic control and direction, rational planning, fixed or capped budgets, and the management of demand by rationing" (Swerissen & Duckett, 1997, p. 34). The commitment to an economic rationalist alternative was serviced by a renaissance of neo-classical economic arguments for the revitalization of the market, emphasizing the importance of competition, individual responsibility, deregulation, private interest in the pursuit of efficiency and utility, changing community expectations, increased demands for services by the community, population ageing and improved health treatment technologies. The heavy dependence of hospitals on the Government for finances, doubts about the efficiency of some institutions, and concerns about their budget overruns, placed pressure on government to provide greater flexibility and consumer choice. The time was ripe for the emergence of the hegemony of economic rationalism in Victoria.

The budget reduction targets of the new Liberal Government (1992) could not have been met without the assistance of a significant change in the industrial environment in Victoria. The Government quickly introduced legislation which changed dramatically the pre-existing industrial relations framework, replacing a centralized system based on arbitration, with one based on individual employment contracts. The new industrial environment

weakened the bargaining positions of unions in the health sector and facilitated the staffing reductions necessary to achieve the health sector budget targets (Duckett, 1994).

Prior to the 1980s, for budgetary purposes, Victorian hospitals were subject to detailed input controls, including specification of the number and type of staff to be employed, and detailed specification of various categories of non-salaried expenditure, such as pharmaceuticals. This detailed input control was slowly relaxed into broad headings of salaried and non-salaried expenditure (Duckett, 1994). The mid-1980s saw the advent of "health service agreements" which provided more autonomy to hospitals, and replaced detailed input control with broad specification of expectations of hospitals, in terms of the number of patients treated. Funding was provided to hospitals in a single broad category, or "global budget". This new "output orientation" of health service agreements was much trumpeted by the Health Department and Government as a key method for improving hospital efficiency. This was not a universally accepted view. In fact, health service agreements did little to change historical funding arrangements in terms of either patient flows or efficiency (Duckett, 2000). A parliamentary review (Economic and Budget Review Committee, 1992) found that "while health service agreements may have contributed to overall efficiency gains there is little tangible evidence to indicate that they have tackled the problems of discrepancies in hospital performance ... health service agreements have not achieved a significant move from historical patterns of funding" (Duckett, 1994, p. 16).

In 1986, a selection of Victorian hospitals began to use Diagnostic Related Groups (or DRGs), to assist in their quality assurance programs. However, because of their design

characteristics, and in particular because patients in the same DRG were expected to consume similar amounts of resources, DRGs were able to be used to standardize for differences in the casemix of hospitals, and thus allow comparisons of hospital efficiency (Duckett, 1994). This development was to be the forerunner to a major shift away from historical funding patterns in Victoria.

In the period before 1993, relationships between Victoria's 150 public hospitals and the Health Department were principally the responsibility of the Department's Regional Offices, of which there were three in the State Capital (each being responsible for about 25% of the overall State hospital budget) and five in rural Victoria (together accounting for the remaining 25% of the budget). Public hospitals in the State treated 7,000,000 inpatients in the 1992/1993 fiscal year (Duckett, 1994) and commanded a budget of slightly over \$2,000 million, 75% of which was allocated to the 30 largest hospitals (Duckett, 1994). In comparison, Australia's total expenditure on health was \$35 billion, of which the Commonwealth government provided \$15 billion, the States and local governments \$8.5 billion, and the private sector (individuals and payments by health insurance funds) \$11 billion.

Lin and Duckett (1997) noted that hospital services in Victoria, as in the rest of Australia, were provided by a mix of public and private hospitals. About a third of hospital beds in Victoria were in the private sector, about two-thirds in public hospitals. Compared to other States, however, Victoria had the largest private sector and also the highest rate of private health insurance, albeit with the most rapid rate of insurance decline. By 1997 there were about 150 public hospitals in Victoria, costing the State government over \$2 billion per

annum (Lin & Duckett, 1997, p. 47). Unlike in the United States of America, the leading hospitals in Victoria, with a strong research involvement and high quality provision of medical programs, were to be found in the public sector. For example, Victoria's heart transplant and liver transplant programs were in public hospitals, and in 1997, four of the State's five magnetic resonance imaging scanners (MRIs) were in public hospitals.

Public hospitals in Victoria had traditionally exercised substantial autonomy. Regional administration and area health services arrangements in Victoria, unlike other States such as New South Wales, had never been strongly supported. The public hospitals had been represented through a strong industry association, the Victorian Hospitals' Association (VHA), and had been "adept at manipulating the media to ensure that their concerns are brought to the attention of the government and the public" (Lin & Duckett, 1997, p. 48). Although hospital boards were appointed by the Health Minister, new board members quickly saw themselves as representatives of "the community" and advocated the interests of the hospital, rather than being beholden to government. Lin and Duckett (1997) pointed out, moreover, that their advocacy was defined around hospital, rather than health care system, interests.

Until the mid-1980s, hospitals in Victoria were funded historically on an inputs basis, such as salaries and pharmaceuticals. Hospital budgets were generally "rolled over" from the previous year, with adjustments made for award variations based on approved staff profile, and indexation of non-salary costs. With little explicit reference to differences in activity levels, budget reductions arising from the overall economic context were often achieved by reducing services. Commencing in the mid-1980s, detailed input controls over hospitals

began to be relaxed and hospitals moved to "global budgeting", where hospitals had autonomy to shift funds between various classes of inputs (including different personnel categories), and between salary and non-salary expenditure. This change was accompanied by an increasing emphasis on measuring the total activity levels of hospitals, such as the number of patients treated, although the link between resource input and output remained weak. "The funding and political systems rewarded advocacy skills rather than efficient management" (Lin & Duckett, 1997, p. 48).

Changes in Funding and Organization

In October, 1992, the Australian Labor Party (ALP) government in the State of Victoria was swept out of power in a landslide election. The conservative Liberal-National coalition came into power with popular support for sweeping changes in all areas of social and economic policy. In the health arena, the pre-election policy statement promised that the eight regional offices of the State Health Department would be abolished (Lin & Duckett, 1997). Instead, five area health authorities would be established and purchaser/provider arrangements would be introduced. The stated purpose of the policy was "to move away from a central, bureaucratically run health system to one which was more competitive and responsive to its customers" (Lin & Duckett, 1997, p. 47).

Shortly after its election in 1992, the Victorian Liberal-Coalition government appointed a Commission of Audit to assess State finances. The Commission of Audit (Commission of Audit, 1993) claimed that Victorian acute hospitals (hospitals that provided services for acute illnesses and emergencies) were 18 percent more expensive than acute hospitals in

other States. These data corroborated data published by the Commonwealth Grants Commission (which assessed the performance of the public sector in all of the States) which had already indicated that Victorian hospitals were relatively inefficient. This evidence was used by the State Treasury to justify imposing substantial budget cuts to the hospital sector in Victoria.

The Victorian Health Department also supported the view that public hospitals had scope to achieve efficiency savings. The department had, for almost a decade, been involved in analysis of hospital performance using casemix data. Unlike other States in Australia, Victoria had published comparative hospital length of stay by Diagnostic Related Group (DRG) since 1982. Victoria had also published comparative data on cost per patient treated, adjusted for casemix using DRGs. Lin and Duckett (1985 cited in Gardner, 1997) have put this on record. A review of the Victorian hospital system, conducted shortly before the 1992 election, recommended a move towards casemix funding for larger hospitals over a five-year period (Health System Review, 1991, cited in Lin & Duckett, 1997). The Victorian Health System Review (1991) had identified a range of problems in the funding framework for the public sector health system. These included the lack of explicit links between level of funding and the output of hospitals; the lack of incentives to increase efficiency; the issue that existing historical practices did not encourage tight financial management; and the issue that the system of global budgets was more linked to cost than to efficiency. Following internal consideration, the department issued a circular which foreshadowed a move to casemix funding commencing on July 1, 1993, but to be implemented over a two-to-three year period (Lin & Duckett, 1997).

The new government (1992) appointed a new Head of the Department of Health (renamed the Department of Health and Community Services). As an economic rationalist with experience in price and work practice reforms, and in common with other economic rationalists who had come to dominate the bureaucracy (see Pusey, 1991), the new Head of Department saw the health system as "primitive and sovietized", and characterized the relationship between the department and the hospitals as one of "co-dependency". Although the new government supported a purchaser/provider split, the new Head of Department saw the purchaser/provider system as creating bigger bureaucracies, and preferred instead to use financial levers to create change. He was able to convince the Minister for Health to defer the introduction of both area health authorities and purchaser/provider arrangements, and instead introduce casemix funding. Accordingly, the government gave priority to introducing casemix funding as a way of driving efficiency improvements (Duckett, 2000).

A prerequisite for casemix funding was greater clarity in describing hospital activities, since product definition is the *sine qua non* of market reforms: without a meaningful definition of products comprehensible to both the purchaser and the provider, there can be no market. Clarification of hospital products occurred through "unbundling" of hospital activity by first defining broad product lines. Casemix funding also required, for each of the major product lines, specification of prices and a limit on the volumes of activity to be funded, to ensure that expenditure targets were not exceeded.

Three broad streams of hospital products were identified: in-patient services, out-patient services, and teaching and research functions (known as "training and development").

Other services that could not be specified in the three broad streams, for example, home-care services, were captured in what were called "specific grants" or "site-specific grants" that continued to be made by negotiation (Duckett, 1994; 2000). In each case the broad product line needed to be further refined to classify the casemix, or detailed functions, within that broader stream. "By far the greatest attention [was] paid to the development of payment systems for in-patient services and the consequent need to describe in-patient activities of hospitals" (Duckett, 2000, p. 152). The typical initial approach to in-patient payments was to implement a statewide standard contract with all hospitals.

The initial purchasing focus in Australian casemix funding and implementation involved an attempt to bring hospitals attention to the number of patients on surgical waiting lists, and hence to change (or provide incentives for hospitals to change) hospital admission priorities. It built on a history of "categorization" of waiting lists, where surgeons classified waiting-list patients in terms of the urgency of their admission; Category One was the most urgent, requiring admission within thirty days. Category Two was the least urgent, requiring admission within ninety days. Duckett (2000) cites an example of a Category One patient as one who would be requiring open-heart surgery, while a Category Two patient on the other hand might require a hip replacement. This categorization process also helped focus attention on the arguably more appropriate measure of excess waiting times, rather than a simple count of those waiting.

Casemix funding, as implemented in Victoria, provided funding for activity (the work that the hospital undertook). There was also additional funding from an "additional throughput pool". This was a single statewide pool that was used to pay for all increases in the number

of patients treated in the particular budget year, compared with the base period (which was generally the hospital's activity level in 1992/93). Essentially, the additional throughput pool was the source from which all increases in activity were funded. The pool was allocated on a quarterly basis, as a percentage of a hospital's share of the total statewide increase in activity. The amount of money in the pool available to pay for volume increases was fixed. Consequently the price paid per case varied intensely with volume. The additional throughput payments were made on a quarterly basis with no speciality-specific or DRG-specific targets.

The intention of the Victorian Government's policy was that after 1 January, 1994, hospitals were not to be eligible for any payments from the additional throughput pool if they had any Category One patients waiting for more than thirty days. Importantly, access to the pool was perceived by hospitals as a reward, for many hospitals planned to offset budget reductions with additional payment for additional activity. Thus the throughput pool acted as an incentive that allowed the reduction of Category One waiting list patients. Not surprisingly, the number of Category One patients waiting more than thirty days declined precipitously over this period (Duckett, 2000). The Government was not able to impose a similar elimination target on Category Two patients waiting more than the target period, as there were substantially more of these patients waiting, and hence elimination was not seen as feasible in the short term. Moreover, because categorization was done by surgeons, it was often very difficult to audit the categorization process; some of the reduction in Category One and Two waiting lists was, arguably, achieved by reclassification, rather than by ensuring that those patients were treated.

The additional throughput pool provided a major incentive for hospitals to reassess their admission priorities, and give greater priority to patients on the urgent waiting list. Duckett (2000) assessed the strategy as a rather crude approach to priority-setting, since definition of patients to be accorded priority remained in the hands of hospitals/surgeons. There was no attempt to weight elective patients; for example, to give a higher priority to orthopaedic versus cataract patients.

In 1995/96 the additional throughput pool was abolished in the State in which we are interested, that is Victoria, for reasons including the issue of early discharge in order to increase volume and thereby receive the concomitant increase in funding. “Anecdotal evidence suggests that there has been an increase in the number of people discharged earlier than the previous practice” (Duckett, 1994, p. 87). Duckett (1994) noted however, that while this phenomenon might have been an over-reaction by hospitals to the new casemix funding arrangements, it might also have been caused by a systematic shift in the nature of patient care. Draper (1999) however informed us that “discharge planning has not been a strong feature of Australian hospitals ... [moreover] hospitals are often insensitive to people’s social circumstances” (p. 143). The priority-setting process was now refined, with specification for the first time of hospital-specific volume limits (hospitals were now unable to access additional funding by increasing their throughput), rather than volume of activity (and thus payments) being calculated on a State basis. This change marked the transition from a "budget share" approach to a clearer purchaser orientation in payment policy, as the precise volume to be purchased at each hospital was now determined centrally. Payment for additional activity (above the base, plus a small flexible margin)

was now allocated to hospitals using approaches that involved making centralized judgements about where additional activity was warranted in the State (Duckett, 2000).

The State in which we are interested, Victoria, and one other, South Australia, were both involved in significant budget reductions, where the chief policy objective was presented as being about increasing technical efficiency very rapidly. Duckett (2000) declared that "the alternative economic objective, of improving allocative efficiency was not a high priority in the implementation process, reflecting the market-oriented rather than planning-oriented emphasis of Government in both States" (p. 157). The technical efficiency orientation of the changes in hospital funding meant that these governments relied on the development of good measures of output, mainly casemix measures, and on such methods being widely accepted in Australia. Moreover, the various State casemix policy measures concentrated on simple description of the product in output terms, while measurement of quality of care was not emphasized. Although the initial Victorian introduction of casemix funding was associated with an emphasis on analysis of readmission rates and the development of a statewide patient satisfaction survey, the results of analyzing these data were not released until 1997 and 1998 respectively. While there was almost no official before and after documentation information to demonstrate any impact on quality, a Report by the Auditor General of Victoria (1998) noted that hospital staff certainly believed there was an adverse impact on quality. Conversely, patients were, by and large, satisfied with their experience in hospitals. Seventy seven percent of patients surveyed in the statewide satisfaction survey reported that they were very satisfied with their care (Victorian Commission of Audit, 1998 cited in Duckett, 2000). The data was published as part of a discussion paper (Health Services Policy Review Discussion Paper) recommending "a process of evaluating

appropriate indicators of quality care in hospitals" (Phillips Fox & Casemix Consulting, 1999, p. 136).

Since the late 1970s, concerns about cost increases and about the management of public hospitals, generated in part by Commonwealth inquiries, made the States become much more active in intervening in the affairs of these institutions. Palmer and Short (2000) cite as examples the Hospital and Health Services Commission (1978) and the Commission of Inquiry into the Efficiency and Administration of Hospitals (1981). The heavy dependence of the hospitals on the States for finances, together with doubts about the efficiency of some institutions and concerns about their budget overruns, were the principal reasons for this change in State policies.

In October, 1992 the Labor Government in Victoria was swept out of power in a landslide election (Duckett, 2000). The election of a Liberal State Government represented a turning point in the way public hospitals were funded and in the way health services were managed in Victoria. The new Government was committed to substantial budget savings and dramatic reform of the hospital system. The opposition spokesperson since 1989, a lawyer by profession, was appointed as the new Minister for Health and the first Minister of the new Department of Health and Community Services in Victoria. Two other Ministers (the Minister for Community Services and Aboriginal Affairs, and the Minister for Aged Care) were appointed to support the new Minister. A new "mega department", one of 12 departments compared to 22 under the former Labor Government, accounted for about one-quarter of State budget expenditure and employed, prior to "voluntary departures", in excess of 15,000 staff (Barraclough & Smith, 1994, p. 11). The subsequent merger of the

former Health Department Victoria and Community Services Victoria into the Department of Health and Community Services led to the creation of seven major programs: acute health services; aged care; disability services; psychiatric services; child and youth protection; public health; and primary care, together with a central support program (called Resources) (Duckett, 1994).

The merger of the Departments of Health and Community Services led to an organizational restructuring in which nine regions were each headed by a Regional Director, with Managers responsible for each of the programmatic areas of the Department. Unlike the previous government's program, the new program and divisional structure provided a very clear framework for policy development and funding responsibility within the Department, and allowed for concentration of policy development within a single organizational sub-unit. Public hospitals, however, were providing a broad range of services, cutting across many of the new programs of the restructured Department. For example, major hospitals such as the Alpha Hospital, (one of the hospitals at the centre of this research) generally provided psychiatric services which, in the previous program structure of the Department, had been allocated to a specialized mental health facility. A major task which took place simultaneously with the planning for the introduction of casemix funding, then, was the disaggregation of hospital budgets into the new departmental programs. This facilitated the introduction of casemix funding, as many of the areas transferred out of the acute health programs (for example, psychiatric services) were not well described with casemix measures, and hence would not be amenable to casemix funding. Duckett (1994), who declared himself "a longtime casemix proponent"

(p. 8) saw Victoria by this time "as ripe for the introduction of casemix funding with ... a climate which facilitated rather than obstructed the introduction of the 'innovation'" (p. 10). Upon taking office in late 1992, the Treasurer required immediate action from the Minister of Health to reduce outlays so that the Government could reduce Victoria's current account deficit, then approaching \$1 billion, and projected to increase to over \$1.2 billion by 1994-95. The wider budgetary implications of the situation were recognized and acknowledged by the new Health Minister. "Victoria is at its financial crossroads and Health and Community Services, being the department with the largest financial appropriation, must meet its share of the financial constraints imposed in the interests of the long-term future of all Australians" (Barraclough & Smith, 1994, p. 9). The Minister "was committed to achieving these cuts" and "would not tolerate any opposition" (Lin & Duckett, 1997, p. 52).

Early in its tenure, the new Government instituted a Commission of Audit, with the task of taking stock of Victoria's finances, investigating aspects of the performance of Victoria's public sector in comparison with other States, and suggesting ways to reduce expenditure and improve activity. The Commission of Audit (Victorian Commission of Audit, 1993) "claimed that Victorian acute hospitals were 18 percent more expensive than hospitals in other states" (Duckett, 2000, p. 151). The Commission recommended, inter alia, that action should be taken to eliminate restrictive work practices, including day nursing shift overlap, the rationalization of hospital services through joint or network arrangements, and the commercialization of non-core services. A further recommendation was that public and private hospitals be encouraged to compete with one another. These recommendations helped move the Government towards a purchaser-provider split as its approach to the organization of health services.

Up to, and including this time, the policy environment within which Victorian public hospitals functioned still bore the traces of the charitable antecedents of hospitals and the Government agency which regulated them, the Health Department Victoria. Although Boards of Management of public hospitals were appointed by the Governor-in-Council on the recommendation of the Minister for Health, public hospitals did not see themselves as part of the Government, nor answerable for their activities to the Health Department (Duckett, 1994). Duckett (1994) has pointed out that from the Department's point of view, Victorian hospitals had a very large degree of autonomy and independent political power, with little accountability. Nevertheless, both the Department and the hospitals profited from this arrangement "as they could each blame the other for system failures" (Duckett, 1994, p. 15).

Now, however, in addition to its insistence that the health budget must be substantially reduced, "the new government enthusiastically embraced managerial approaches which stressed the management of output and sought to reward increased productivity" (Barraclough & Smith, 1994, p. 10). The Government's economic activity included three major health strategies for meeting these goals: casemix, health budget rationalization, and networks.

Casemix

The introduction of casemix funding in 1993, as pointed out earlier, represented a shift from global budgets to output-based budgets, thus completing the transition from the input funding of the earlier period. Casemix funding changed the perception that hospitals

owned their budget: funds were again seen as public (Government) funds, and hospitals would be paid according to what they produced. This represented a sea-change in that there were no longer hospital budgets in the traditional sense. Even so, the 1993 arrangements saw the introduction of a funding formula, with each hospital able to develop its own budget according to its own forecast of the number of patients it would treat (Duckett, 1994, 2000). In addition to their expenditure budgets, hospitals also had revenue budgets. Under the provisions of the Commonwealth-Victoria Medicare Agreement (1988-1993) hospitals could not discriminate between patients on the basis of their insurance status or whether they were to be admitted as public or private patients. The policy consequence of this was that hospitals could not bear the risk of any change in their mix of public/private patients. Accordingly, hospital revenue budgets were adjusted retrospectively to take account of the actual mix of patients in the hospitals in the financial year. These procedures were largely maintained under the casemix arrangements introduced in July, 1993 (Duckett, 1994).

Victoria thus became the first State to introduce this new funding system, which had been recommended by the National Health Strategy and was supported by the previous Labor Government in Victoria. As discussed earlier, a significant portion of the budget of hospitals was now based upon the volume and complexity of cases treated. Reimbursement was calculated upon costings considered to be based upon best industry practice. This system introduced a strong performance factor into public hospital funding. Further in keeping with its commitment to performance-oriented funding policies, the Victorian Government required public hospitals to contribute one percent of their budgets to an

earmarked pool which would be used to reward hospitals which cleared all Category One waiting list patients by a set time (Barraclough & Smith, 1994).

Budget Rationalization

The mere introduction of "casemix funding" was never the objective of the funding reform however (Duckett, 1994, p. 20). Rather, it was the means to an end; a way to restructure hospital funding arrangements to introduce financial incentives, in order to achieve three specific objectives: to introduce a fair basis for funding hospitals in the context of an overall budget reduction; to improve the efficiency of public hospitals, and to provide for an expansion in the number of patients treated, and thereby to allow a reduction in them.

The Government had made a pre-election promise to reduce waiting lists and was concerned to ensure that the budget reductions did not lead to an increase in them. Previous attempts to reduce waiting lists had demonstrated that mere increases in the number of patients treated were not enough to yield reductions in waiting lists, and therefore it was important to ensure that any increase in patients treated gave priority to patients on the waiting list (Duckett, 1994).

The design of the case payment service took place within the context of the overall philosophical direction of the new Government. The wider economic agenda, as iterated by the Victorian Treasurer, was to achieve, amongst other things, "considerable efficiency improvements in core delivery areas" (Barraclough & Smith, 1994, p. 9). Within the auspices of the prevailing economic rationalist imperative all new spending measures

approved by the previous government were frozen, with an immediate freeze being placed on all capital works projects, no contractual agreements being based on new wage and enterprise agreements, and immediate reductions being demanded in the Department of Health and Community Services workforce. The implications for the Department were clear. Under these conditions it is not surprising that the Minister for Health placed an emphasis on purchasing (or paying for) services for patients, rather than on funding institutions. The implication of this was that the Government was not concerned about the fate of particular hospitals under the case payment arrangements, provided that the patients could be treated elsewhere.

The emphasis on "the money following the patient" was an important core principle of the design of the casemix arrangements (Duckett, 1994, p. 23). A corollary of this approach was that the Government was indifferent as to where patients were treated: as far as possible the funding formula was thus designed so that all hospitals should be paid on a similar basis with few, if any, supplements to the patient related payments based on the characteristics of the hospital where the patient was treated. As Duckett (1994) observed, "this effectively neutralized much of the political leverage of the large, high-prestige institutions" (p. 24), such as the hospitals examined in the present case study.

Networks

In Victoria, the introduction of casemix and accompanying major budgetary cutbacks (Victoria removed \$220 million from hospital budgets over two years) was soon followed by the third major reform measure - the implementation of "hospital networks" (Draper, 1999, p. 141). The health care system of the future would then "have the capacity to

deliver the full range of health services effectively, efficiently and in the manner preferred by consumers. The key to realizing this vision is the creation of provider networks” (Metropolitan Hospitals Planning Board, 1995, p. iii).

The need for major change in the provision of hospital services was identified in the Metropolitan Hospitals Planning Board Interim Report (1995). Amongst other deficiencies in the system as it stood, there was a concentration of hospital services in inner Melbourne. Medical services catered for an ageing population, thereby calling for more emphasis to be given to the treatment and care of people with chronic, but generally manageable, diseases and disabilities. The Report highlighted a reduction in hospital length of stay which could provide an opportunity for the undertaking of more procedural and diagnostic work in short-stay centres, geographically separate from hospitals (Metropolitan Hospitals Planning Board, 1995). Generally, there was perceived to be a need for new management practices with increased emphasis on patient-centred care in smaller care settings, which would be more accessible to the community. It was recognized that while technical efficiency was well established in Victorian hospitals, broader issues remained in relation to the structure and coordination of services in an industry characterized by a complex set of interactions and incentives at all levels, both within and across the health system. The relationship between cost, quality and health outcomes for the consumer had become paramount for the Government. The issue to be addressed was that there was a point beyond which additional resources would "not improve quality and might even reduce it ... [There was a need, therefore] to consider broader structural reform and to develop a rational basis to plan services for the longer term" (Metropolitan Hospitals Planning Board, 1995, p. 7).

The status quo warranted critical attention. As things stood in Victoria, there were in existence thirty-five stand-alone public hospitals, each with its own clinical staff, corporate structure, administration and support structures. Each hospital was independently pursuing its own vision, within a complex and rapidly changing health care environment, with limited collaboration and responsiveness to the needs of the community.

Furthermore, each hospital had its own Board. The role and composition of "traditional" hospital Boards was described in the Interim Report (Metropolitan Hospitals Planning Board, 1995). Before the establishment of networks, guidelines covering the roles and responsibilities of hospital Boards were spelled out by the Health Services Act 1988. Under this legislation the Board of a public hospital was a Board of Management. Its role was to oversee and manage the hospital, ensuring that services provided by the hospital complied with the requirements of the Act and the overall objectives of the hospital. Under the Act, Boards comprised between six and twelve members. If the hospital was affiliated with a university, then one additional member of the Board had to be a representative of that university. Of the other members, only one quarter of the Board (excluding the university representative) could be medical practitioners. Traditionally, Board members included members from diverse backgrounds. Board positions were generally honorary and Board members were expected to sit on committees, the number of which could be quite substantial. Advantages of this model included representation on Boards of a wide variety of interest groups. Disadvantages of this Board model included a primary focus on operational issues at the expense of more strategic ones, a potential for conflict between the Board and management, and lengthy meetings resulting from the involvement of the large numbers of its members.

The Interim Report (1995) however, made recommendations for the structure of future network Boards. It was proposed that hospitals would be aggregated into a network under a single Board. "It is likely that future hospital Boards will be more akin to Boards of Directors and in fact be Boards of Governance" (Metropolitan Hospitals Planning Board, 1995, p. 56). They would have a balanced mix of skills and experience, and a smaller number of committees. While Board members would continue to be appointed for three years as before, a leaner "tighter" (p. 56) structure was proposed. Moreover, the role of Board members would no longer be honorary, with payment of members being commensurate with responsibilities and accountabilities. Advantages of this model included a recognition of the need for greater commercial focus, responsiveness to community and customer concerns, and accountability for its decisions. Disadvantages of this model included the risk that commercial considerations and decisions might dominate at the expense of clinical issues and quality of care. There was also the risk of the Board excluding management from the decision-making process, but it was proposed that these problems could be minimized by active involvement of senior managers, including clinical managers, in giving advice to the Board and in preparation of the hospitals strategic plan and budget (Metropolitan Hospitals Planning Board, 1995).

The Interim Report identified "the need for major change in the provision of hospital services" (Metropolitan Hospitals Planning Board, 1995, p. 3). Major impediments to change noted in the Report included outdated hospital locations, with over 30 percent of the State's acute hospital activity occurring in just six teaching hospitals, located within a five kilometer radius of Melbourne. As well, the report identified a disparity of access to services, predicted to increase due to population growth on the city's outer fringes.

Historically, there had been a large investment in metropolitan public hospital buildings and land. What had eventuated was a fragmented system caused by too many individually run hospitals and other service providers (Metropolitan Hospitals Planning Board, 1995).

The Interim Report of the Metropolitan Hospitals Planning Board (1995) proposed considerable changes, contributing to its vision for a substantially re-formed health care system. The key to realizing this vision was to be the creation of health care networks by incorporating tertiary acute hospitals, community acute hospitals and aged care services. The term "tertiary services" generally refers to inpatient services which require twenty-four hour access to highly specialized medical, nursing and allied health staff, expensive infrastructure and a comprehensive range of investigations. Consequently, these services are high cost, require a sufficient numbers of patients to maintain expertise and quality, and cannot be immediately available in every community. It was felt that as most patients rarely need access to such services, travelling some distance would be generally acceptable. It was envisaged that the integration of services would take place in sub-regional geographical areas servicing a common community. Services would be aggregated to avoid some duplication and to promote better continuity of patient care. Not all networks would include a tertiary hospital or extended care centre, and so links would need to be maintained with networks that contained these services. While tertiary hospitals would be incorporated into some networks, they would also be required to serve networks without tertiary services (Metropolitan Hospitals Planning Board, 1995).

Each of the proposed networks would have considerable scope to develop health services to meet the changing needs of the community. A range of community acute health care

services and ambulatory care clinics would be divested from the inner capital city and distributed throughout the networks to make services more accessible to the communities they served. This would generally require the downsizing of the major city hospitals, leaving, however, appropriate tertiary services (for example, specialist units such as cardiology, urology, and so on) and those community services necessary to serve inner city communities. State-wide and super - speciality services (for example, cancer services, infectious diseases, obstetrics, paediatrics, eye and ear services) currently contained within networks, would retain their State-wide focus and be subject to strategic planning guidelines to prevent unnecessary duplication across networks (Metropolitan Hospitals Planning Board, 1995).

Seven networks were recommended by the Interim Report. Five geographical networks were to incorporate community hospitals, a major tertiary referral hospital, an extended care system and mainstreamed psychiatric services. One exception, the sixth network, was the Seaside Network which had no tertiary centre. This sixth network and yet another, the seventh network incorporating a major children's centre and a women's hospital, were seen to have a more specialist focus. This range of resources would enable networks to redirect services to the middle and outer suburbs within an overall strategic framework (Metropolitan Hospitals Planning Board, 1995).

Each of the networks was to have a growth path. For example, the Area Network that concerns this research was intended to incorporate the amalgamated Alpha and Beta Hospitals as the Delta Medical Centre; an extended care centre; an infectious diseases hospital; a women's hospital; and a new community hospital. The developmental tasks to

be undertaken in this network were considerable, including the Delta Medical Centre redevelopment, and the development of a new community hospital at the geographical extreme of the new network. In order to ensure the effective planning of these services, it was imperative that this network be formed immediately to ensure rational planning for the needs of its community. This network would focus, in particular, on providing services in the outer reaches of its geographical location, where there was a growing population and a need for obstetric services. It was intended that by bringing these services under one Board, the needs of the area could be re-evaluated to ensure that developments incorporated all services in the network. The size of developments at the Delta Medical Centre was to be reviewed, allowing for smaller facilities around the network, rather than permitting a large concentration of services on the Delta Medical Centre site (Metropolitan Hospitals Planning Board, 1995).

Adeney (1997) looked at the new network system applying to metropolitan hospitals in Victoria, and evaluated the legislative process by which it came into being. She noted a new classification of hospital was created by the *Health Services (Metropolitan Hospitals) Act 1995*. Public hospitals which had been run by their own Boards of Directors as charitable institutions receiving the bulk of their funding from the Government, but also substantial amounts from public donations, abruptly ceased to be legal identities in their own right, capable of holding land or entering contracts in their own name, suing or being sued, or exercising any of the other functions of a corporate entity. Instead, mega-hospitals had been created, of which the previous corporate entities were now campuses or facilities. That is, they would have physical and administrative, but no longer legal, identities. The new "metropolitan hospital", or network, "would have a Board of Directors which would

have ultimate control of all the health care campuses in the network. It would hold the land on which they were built and enter all contracts for services and employment in its own name" (Adeney, 1997, p. 271). "What it [the hospital] will retain is a name, including a reputation, its own administration and as much day to day autonomy as possible. This will be its identity" (Adeney, 1997, p. 273). Adeney (1997) concluded that what can be seen in the move to networks was a process of centralization of power in the hands of network Boards, and thus easier control of the system as a whole by government.

Much of this policy, then, represented responses to the State problems of hospital inefficiency, and budget over-runs. These problems led the States, including the State of Victoria, to consider three major policy areas needing review. The first concern was how to strengthen the capacity of the State health authority's ability to plan and regulate the hospitals and other health services. The second was how to regulate and plan activities designed to change the ways in which hospitals operated, in terms of both their internal activities and external relationships. The third consideration was how to use the funding of hospitals to achieve policy objectives, such as increasing efficiency (Palmer & Short, 2000).

The National Health Strategy (1991a) report on hospitals emphasized the need for reforms to improve the efficiency, equity and quality of services provided by both the public and private sectors. This report also drew attention to the need for further reductions in the number of hospital beds per 1000 head of the population, that by 1990 had fallen to 5.0 from a peak of 6.5 recorded in 1980 (Palmer & Short, 2000).

Palmer and Short (2000) noted that concerns about the quality of care provided in public hospitals centred on the fact that there was still insufficient effort made to monitor and review it in most hospitals, despite the exhortations of health ministers and others extending over a 23 year period. For example, one survey by the Australian Institute of Health reported by Renwick and Harvey (1988) revealed "that extensive quality assurance activities in public hospitals were limited to a minority of institutions" (Palmer & Short, 2000, p. 91).

Palmer and Short (2000) noted other studies of public hospitals (for example, Enquiry into Hospital Services in South Australia, 1983) were critical of the lack of coordination and integration of the activities of individual hospitals, both with one another and with other elements in the health care system. The Enquiry into Hospital Services in South Australia (1983) found that the larger hospitals tended to provide all of the most specialized and expensive services, "in some instances justifying this process by reference to their roles as teaching hospitals" (Palmer & Short, 2000, p. 91). As a consequence these services were under-utilized in relation to the facilities and staff available. It was suggested that a concentration of activities, such as coronary artery bypass surgery, at fewer sites, might have yielded cheaper and higher quality services. The failure to integrate the activities of public hospitals with those of nursing homes, community health services and private medical practice had resulted in an over emphasis on hospitalization and the inappropriate use of these expensive facilities.

The absence of appropriate mechanisms for allocating funds from governments to individual institutions was the focus of increasing attention in the early 1990s. The

allocation methods in force had reflected predominantly the attempt to maintain the financial position of each hospital in real terms in the face of rising prices and costs (Palmer and Short, 2000). The information available to the State health authorities about each hospital was confined to crude measures of usage, for example occupied bed-days, and costs (costs per bed-day and per patient treated). Thus it was not possible to develop criteria that related the funds to be provided, to the outputs produced, even though that might have promoted improved efficiency.

Public hospitals had become major political issues in both Victoria and New South Wales in the late 1980s, and the coalition parties achieved a great deal of success in convincing the electorates that the State Labour Governments were responsible for the crisis that allegedly existed. In respect of federal politics, much of the rationale of the coalition parties' policies for reforming the health care system arose out of the claim that waiting lists for treatment in public hospitals were unduly long, and that changes in the health insurance arrangements to produce a shift to the use of private hospitals were therefore warranted (Palmer & Short, 2000).

As mentioned earlier, part of this shift was to amalgamate some existing hospitals under new Board arrangements. In the period before economic rationalism, the two hospitals at the centre of this research pursued their own private vision of their own future. Each had its own Board, its own clinical staff and administration, its own housekeeping and diagnostic services, and so forth, identical to most other acute-care public hospitals in Australia. The autonomy, it should be noted, of these Boards varied considerably between the States and also according to the size and role of the hospital. Nevertheless, in the years

of universal coverage and free care dominance, the Boards of the major teaching hospitals in Australia enjoyed, by virtue of the high status of their members, a good deal of autonomy, which allowed them to influence the planning of health authorities (Palmer & Short, 2000). This was the case here.

In June 1994, however, the Victorian Minister for Health and the Federal Minister for Veteran's Affairs announced the most significant redevelopment of acute hospital services in Melbourne's Northern growth corridor for the past thirty years (Alpha Hospital, Annual Report, 1993/1994). As part of this redevelopment the Alpha Hospital and the Beta Hospital would merge on July 1st 1995. (Note: The Alpha hospital later succeeded in bringing the amalgamation forward to 1st April of that year). Later the Department of Human Services announced the establishment of a planning committee to plan for and oversee the transfer of the Beta Hospital from Commonwealth to State, the amalgamation of the two hospitals, and their redevelopment on the Beta Hospital site. The core members of this committee, appointed by Human Services, would become the new Board of the amalgamated hospitals, under the chairmanship of a prominent Melbourne businessman who had previously overseen the amalgamation of two large private organizations. All administrative positions were to be rationalized and a single administration was to be appointed. Positions were to be advertised and new appointments were to be made.

In practical terms, the displacement of one hegemony (public bureaucracy) by another (economic rationalism) in 1995, while it produced some benefits, meant ultimately the replacement of one set of problems by another. At the very least, if the sentiments of people working in the hospital system are taken into account, it would seem that the

achievement of greater efficiency in the health system through aggregation and amalgamation, the containment of hospital costs through fiscal policy and funding initiatives such as casemix, and the “taming” of the hospital-based specialists through the abolition of the former hospital Boards, were all achieved to the accompaniment of an acceleration of human pain and distress. There was a price to be paid in terms of morale. This aspect has been addressed by Roan, Lafferty and Loudoun (2002) who noted that "regardless of the organizational intention behind downsizing, the process of change and the employment outcomes can have a dramatic effect on employees' working and personal lives" (p. 1). This we will see for ourselves in later chapters that analyse and discuss this research data in more depth.

A SUMMARY AND SOME COMMENTS MADE

Reorganization of State health authorities, for example, the regionalization of health services into districts or networks; regulation and planning of hospitals activities through closures and amalgamations; financial reforms in the form of funding hospitals through casemix and budget control, can all be interpreted as activities representing attempts by State and Commonwealth Governments to move health away from the area of public bureaucracy discourse and towards the hegemony of economic rationalism (Palmer & Short, 2000).

The perspective on health policies provided by Alford (1975, cited in Gardner, 1997; Hancock, 1999; Palmer & Short, 2000, Stoelwinder & Viney, 2000) serves as a useful guide to the interpretation of the frequent modifications to the organization of the State health authorities, and the limited changes that these and their associated inquiries have produced in the provision of hospital and other health services. Alford's basic thesis was that the health services were the scenes of conflict between two major groups, the professional-monopolizers and the corporate-rationalizers. In the Australian environment these could be identified as hospital-based specialists and senior health authority executives respectively. Members of the former group wished to retain the status quo, whereas those of the latter perceived their interests as being served by the promotion of health planning, and by the achievement of a greater measure of rationality in resource allocation. This resulted in conflicting discourses.

Where these conflicting structural interests were evenly matched, the result was described by Alford (1975, cited in Palmer & Short, 2000, p. 100) as a state of "dynamics without change". In other words, "a great deal of effort is expended in official inquiries, report writing and reorganizations of the bureaucracy but no changes take place in the delivery of health services" (Palmer & Short, 2000, p. 100). Alford viewed inquiries as being part of the problem, since they tended to legitimize the existing structures of power when a necessary condition for change was the elimination or modification of these structures. One such structure was the hospital Board. Since the Board system in Australia has formed an important part of the structure of hospitals, especially the Boards of the major teaching hospitals dominated by the medical staff and their supporters, the elimination of these Boards may have been perceived by governments as an important step in the process of achieving more fundamental reforms in the hospital system. The existence of separate Boards for each hospital, dominated by medical staff and their supporters, had been potent obstacles to the closing of hospitals.

Regionalization of Services

The most interesting Australia-wide organizational development of the 1990s was the creation of area health services. While States assigned several different names to these geographical and administrative entities, including regions, areas, districts and networks, all embodied the regionalization principle of the decentralization of decision-making and authority. In Victoria, as already noted, the metropolitan hospitals were organized into units called "networks" in 1995. These networks were set up to manage all the public hospitals, the mental health services, the specialist geriatric services and the extended care services. Palmer and Short (2000) speculated that a further, unstated objective of the

creation of area services (or networks) was to facilitate the closure of several smaller hospitals. In the absence of an individual Board to lobby for them (and for the continued existence of the Board) these hospitals were more vulnerable to future rationalization programs.

A majority of health service board (network) members, one can conjecture, may have welcomed such closures and the savings thereby achieved, enabling resources to be redeployed to other activities within their areas. The seven year fixed term appointment of Chief Executive Officers of networks by the Minister for Health, rather than by the Board, may have made these officials more responsive to the hospital rationalization and cost containment policies of the government. The reductions in the number of area health services were also expected to strengthen the ability of the Government to rationalize the public health system in all the States. Palmer and Short (2000) feared, however, that the abolition of hospital Boards and the creation of area health services such as networks, might not have been a sufficiently comprehensive change to enable further reforms of the hospital system to be implemented. Palmer and Short (2000) concluded that it was difficult to point to any notable successes since the establishment of networks, in the achievement of these objectives. The reductions in aggregate bed numbers were distributed across most hospitals, rather than reflecting hospital closures in areas of relative surplus. They hypothesized, moreover, that the process had possibly had detrimental consequences for patient access in some areas.

Regulation and Planning of Hospital Activities

Legislation in each State and Territory gives their health authorities wide powers over their public hospitals. For example, in most States Ministers for Health appoint and dismiss members of hospital Boards and the appointment of the chief executive of each Board is subject to the approval of the State health authority (Palmer & Short, 2000). Increasingly State hospital Acts have spelled out in detail the standards and behaviours required from hospitals for “the payment of the state’s subsidy” (Palmer & Short, 2000, p. 95). This includes the responsibilities of Boards, such as accountability for standards of patient care and for the efficient management of the hospital.

The increased spelling out of roles by the State health authorities, along with the creation of networks, were organizational arrangements seen by Palmer and Short (2000) as designed to “counter the tendency of hospitals to provide services that are not warranted by patient needs or by the capacity of the hospital as indicated by its facilities, equipment and staffing” (Palmer & Short, 2000, p. 96). The objective of networks was to establish a well-defined pattern of referrals between hospitals in a given geographical area, so that patients with specified conditions were admitted only to designated hospitals. The desired outcome of hospital bed redistributions was a greater coordination of the services provided by hospital partnerships, consistent with the role delineation and networking systems. While it remained true that State governments had ultimate authority over the funding of public hospitals, as well as legal power to close hospitals, Palmer and Short (2000) believed that the ability to implement the dictates of role delineation and networking remained somewhat limited in the light of the referral practices of general practitioners and the admitting privileges of the visiting medical staff.

Financial Reforms

Another main objective for both the Commonwealth and State/Territories Governments was to contain the rate of growth of public hospital expenditure. This was achieved, with the growth in real expenditure on public hospitals since 1978 being only slightly greater than the growth of population. Palmer and Short (2000) were of the opinion that "this result represents one of the few successes of policy making in this field" (p. 100). Containment of hospital costs was an important reason why the percentage of Gross Domestic Product devoted to total health spending in Australia had increased at a slower rate than in a number of other countries including the USA. In this period, when the principal objective of economic policy was the achievement of reductions in the Commonwealth and State Governments' deficits, further pressures on governments from the health sector "would have been intolerable" (Palmer & Short, 2000, p. 100). Reductions in the stock and rate of public hospital beds per 1000 head of the population accompanied the restrictions on funding.

Furthermore, the reluctance of hospital administrators and governments to require the development of systems to control hospital admissions, was arguably a sign of the power of the medical profession and of its ability to resist reforms that might threaten its exercise of clinical autonomy. Governments preferred to use the blunter policy instruments of restricting bed numbers and funding, to achieve their objectives. The problem that then emerges is that these instruments, in conjunction with geographical imbalances and staffing shortages, "produce the symptoms of a scarcity of beds, that is, notably lengthened waiting lists, if they are not supported by admissions and hospital role policies and the organizational arrangements required to sustain these" (Palmer & Short, 2000, p. 103).

In their analysis, Palmer and Short (2000) suggested that reform of the funding of public hospitals, by basing the States' financial allocations on the output of each institution as measured by DRGs, was a very important step in the process of redistributing resources between hospitals, and possibly between the hospital sector and other areas such as day surgery centres, coordinated care programs and hospital in-the-home initiatives. Palmer and Short (2000) cited the results of studies in Victoria and New South Wales public hospitals, which strongly suggested that there was considerable scope for policies of redistributing finances in those States (Palmer, 1986; Palmer, Aisbett, Ng, & Lohmann, 1992). For example, for a group of 12 of the larger non-teaching hospitals in Victoria the variation in the cost per inpatient treated, between the lowest cost and the highest hospital cost, was nearly 77 percent. However, the casemix complexity (as measured by the DRG profile) of the highest-cost hospital was only 11 percent greater than that of the lowest-cost hospital. The Victorian study also found that the average inpatient costs for the teaching hospitals was 28 percent higher than for the non-teaching hospitals, even when the differences in casemix complexity were taken into account. An explanation offered by Deeble (1986, cited in Palmer & Short, 2000) with appeal to the proponents of reform, was that the excess costs of some of the university teaching hospitals might have arisen as much from their superior position in the bargaining process, as from the objective needs of teaching and research.

Changes in the method of funding hospitals, given the potential they create for redistributing resources, were therefore likely to be resisted most strongly by the likely losers, particularly the teaching hospitals, such as the Alpha. From the standpoint of

Government however, funding measures possessed the considerable advantage that their implementation was much easier than the planning, regulatory and organizational changes that had been the focus, to date, of State Government health policy making. Palmer and Short (2000) noted that in general, Governments seemed to be more successful at influencing the behaviour of providers by funding measures, than by any other direct, regulatory means. It was this belief in the efficacy of the influence of funding measures which also led to the wish by Governments in Australia to introduce internal market arrangements, based on the separation of the roles of purchasers and providers. It is relevant in this regard to note the conclusion of Palmer and Short (2000) that the major areas of successful implementation of health policies in Australia have been those of health insurance and hospital cost containment where the basic instruments involved are financial. Where public hospitals are concerned, "considerable improvements in efficiency and productivity have resulted, in part from the introduction of more rational methods of funding and information gathering" (Palmer & Short, 2000, p. 134).

This attention to restricting funding was another way of moving the health system away from the public bureaucracy, and towards economic rationalization. As cost consciousness grew, however, so did public concern about threats to the quality of care that was being delivered. Sisk (1998) reminds us that nothing inherent in the concept of efficiency or increased price competition predicts that the quality of care will be improved, or even maintained at past or current levels. Moreover, our national and individual values concerning equity also, arguably, temper the drive for quality and efficiency. It is the case, however, that "making choices and trade-offs among costs and benefits is not new to either health care or other sectors; rationing, that is, allocating scarce resources among competing

desires, has always been taking place" (Sisk, 1998, p. 687). Further, it must be noted that this tension between cost reduction and quality of care was not an isolated concern for Australia alone. As price competition in health sectors grew worldwide, the challenge was to create conditions that safeguarded the quality of care, and rewarded its improvement over time, in a manner that was consistent with the public's preferences. For example, in the case of Great Britain, the reforms of the National Health Service [NHS] introduced in 1991 by Mrs Thatcher's Conservative Government, were driven by much the same set of concerns and ideas that shaped the international vocabulary of debate - in particular, they reflected the widely held belief that the best way of improving efficiency was to change the incentives to providers, and that some form of market - like competition (economic rationalism) was the best tool for achieving this aim. There was nothing special about Britain in this respect, but what did make the British case special was the ambitious scope of the reforms, and the relentless determination with which Mrs Thatcher's Government implemented them. Klein (1995) tagged this "a big bang approach to health care reform" (p. 300).

The 1991 reforms of the British National Health Service were designed to change its dynamics, while preserving its structure and method of financing. The NHS would continue to be open to all, regardless of income, and financed mainly out of general taxation. By contrast, the internal organization of the NHS was altered radically. A system based on hierarchical bureaucratic control (the discourse of government bureaucracy) was replaced by one based on competition between providers, with purchasers acting as proxy-consumers on behalf of their populations (the discourse of economic rationalism). So was

created the NHS's new "internal market"; a system supposedly mimicking the operations of a free, competitive market within a framework of a publicly funded service.

Ultimately, the aim of Mrs Thatcher's government was not achieved, although the reasons for this remain somewhat difficult to establish. Nevertheless, the 1991 reforms clearly shifted the grounds of debate. They demonstrated that familiar issues have to be placed in a new landscape. Klein (1995) differentiated between two competing models of health care: "the model of health care as a secular church" and "health care seen as a repair garage" (p. 327). The church model emphasized planning priorities according to need as defined by the experts. Experts determine the need for health care, frame the appropriate priorities, and implement their policies universally throughout the National Health Service. The garage model emphasized responding to demands as expressed by choice. Here, decisions are driven not by experts but by consumer demands. The NHS experience before 1991 demonstrated the limitation of planning by experts, whereas experience since 1991 has shown that health care markets are not natural, spontaneous creations, but have to be managed and planned in order to ensure that purchasers actually have a choice (Klein, 1995).

Sisk (1998) examined the United States of America experience to determine whether quality of care there had deteriorated as price competition increased, or if it had improved. She found that the information was indeterminate. There was no direct information on the relation between increased price competition and technical quality. The meager information available, coupled with the great flux in marketplace conditions and

organizational and financial arrangements for delivering care, made a case, however, for more intensive monitoring and evaluation in the future.

Chernichovsky (1995) distinguished between the old and newly emerging paradigms of health care. Chernichovsky (1995) noted that health care systems in industrialized societies were classified along a continuum, ranging from market or private (the US approach) at one extreme, to public or State (the UK approach), at the other. For example, community care in the UK had been provided mostly by general practitioners, but under public contract, whereas the American system received more than 40 percent of its financing from government services. The distinction was based on a philosophical distinction, Chernichovsky contended, rather than on a realistic one. No pure system of either kind has ever existed.

Chernichovsky (1995) believed that despite the variety of health care systems in the different nations, "a universal outline or paradigm for health care financing, organization, and management is evolving" (p. 340). This paradigm cuts across ideological (private versus public) lines and across conceptual frameworks (market versus centrally planned) as it combines the principles of public financing of health care, with the principles of market competition, applied to the organization and management of health products and services provision and consumption. Realities and an emerging consensus on several fundamental health care issues - access to care, the role of health care, cost responsiveness to consumers, and regulation of the health care system - are the basis of the emerging paradigm, she said; a paradigm that offers technocratic, rather than ideological, solutions; system efficiency and consumer satisfaction, rather than a particular doctrine.

Chernichovsky (1995) pointed out, the emerging paradigm was based on the fundamental principal that a citizen had a right to a socially guaranteed package of care. In the model embodied in this paradigm, financing is increasingly based upon public finance principles, whereas care provision is increasingly based on competitive principles. Another consideration was the organization and management of care consumption. The organization and management of care consumption can be conceptualized as linked to “managed competition whereby, within preset budgets, institutions rather than individuals purchase care from providers” (Chernichovsky, 1995, p. 345). These institutions can be financed using public finance principles while, at the same time, purchasing care from competing providers.

Under the emerging paradigm, the financing and organization and management of health care functions may be institutionally integrated. Similarly, the organization and management of care consumption and care provision may be integrated. The integration of public finance, and the organization and management of care consumption. leads to publicly financed systems whose pattern of care consumption is organized and managed by public institutions that reimburse the private and other free-standing institutions providing the entitled care to citizens. Integration of the organization and management of care consumption, and the provision function, enables the development of institutions that organize and manage care for consumers, while providing care as well (as in the case of a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or a sick fund that is funded or reimbursed by the State, in full or in part).

Chernichovsky (1995) cautioned that the implementation and operation of systems along the lines of the paradigm now emerging, face many challenges, for example, finding a satisfactory private-public mix; developing appropriate ways to handle investment in expensive new technology; keeping the system flexible while health care becomes increasingly dependent on public finance; and addressing politically the array of vested interests that could obstruct reform. Although based on principles of public finance, private finance remains important in the emerging paradigm. In a free society people cannot be prevented from spending their money as they see fit, including expending it on medical care. The question, therefore, becomes what is the optimal mix of care and control expenditure, for a system that is meant to promote equal access to a basic package? What constitutes "basic" care and what constitutes "amenity" care? (Chernichovsky, 1995, p. 359). Will people purchase additional private insurance or pay extra for services (amenities) that are indeed different from their public entitlement, and if so, will this be at the expense of others who do not hold private insurance or do not pay privately? The issue of private-public mix underscores the painful trade-off between equity and expenditure control, and consumer satisfaction. Chernichovsky (1995) noted that some systems, for example Australia and France, allowed private and public finance and care provision to function under the same institutions.

An apposite issue raised by Chernichovsky (1995) was that, as they become increasingly dependent on public finance principles, health systems must be able to adjust whenever resources begin to contract, in the same way as other public and private sectors of the economy. Under financial stress, and in view of the fact that providers' wages and income cannot be reduced as easily, health systems face several risks: that infrastructure and

equipment may deteriorate; that quality of care may go down with declining supplies and deteriorating equipment; that a black market for health care may evolve; and that private financing may become prominent.

Reforms are costly in many aspects and are bound to be opposed in some quarters, partially because medical care is a sensitive social issue and public intervention is invariably a controversial political issue. The cooperation of the independent medical profession is crucial in health system reform, especially in view of the nature of an emerging paradigm that primarily addresses economic and social concerns. The challenge is to maintain enough flexibility in the current system so that it can be rebalanced with changing circumstances (Chernichovsky, 1995).

In brief, a health care system based on a discourse of government bureaucracy and a philosophy of universal coverage and free care, has been replaced by a discourse of economic rationalism and the freedom for individuals to decide whether, and where, to spend their money on medical services. This is a huge change that has proven as difficult to manage in Australia, as elsewhere in the world.

The next chapter will look at the change management literature. It does this by an examination of some major approaches within this field, viz the classical, human relations, post-modern, interpretive, and cultural. Then taking the work of Mirvis and Marks (1992), who reviewed these approaches within the context of a merger, their emphases on the cultural, psychological, and strategic management perspectives are married to the data

generated in this research. The chapter concludes with an exploration of the management of mergers.

This leads to the chapter on survivor syndrome, which is given a chapter to itself in order to emphasize the importance, to organizations, of treating the survivors of a merger with the same regard and assiduousness as they treat those who they retrench. Chapter Four contains the justification for the choice of narrative theory as a guiding theory, and Chapter Five discourses the use of Case Study as an appropriate vehicle with which to examine a specific event (in this case a hospital amalgamation) with a view to providing insights into a particular phenomenon (the experience of survivors of an organizational merger).

The narratives of the survivors are presented in Chapter Six. The researcher has taken the data from the narratives and conflated these into one narrative so that the survivors are speaking as with one voice. This is possible because in their own ways everyone involved in the research expressed the same emotions arising out of their lived experience. Due to the necessity of maintaining the confidentiality of the respondents, the data has been organized by themes, identified from the actual words of respondents within each hospital. The final chapter revisits the major ideas presented in the thesis, and presents some lessons that it would be well for governments, organizations and individuals to learn when faced with implementing a major change program.

CHAPTER TWO

THE LITERATURE AND RESEARCH ON CHANGE MANAGEMENT

Introduction

As noted in the close of the previous chapter, the change management literature is examined here through some of the major approaches in the field, these being the classical, human relations, post-modern, interpretive, and cultural. As the case presented in this thesis is centred on an amalgamation, or merger, it seemed appropriate to use the work of Mirvis and Marks (1992). They reviewed a number of change approaches viz the cultural, psychological, and strategic management perspectives, specifically in the context of a merger and this chapter marries together their work with the data generated in this study. The chapter concludes with an examination of the management of mergers.

“Organization theory, it is generally conceded, is aimed at the better understanding of organizations and how they work, in the pursuit of goals or ends” (Nelson, 2002, p. 32). One of the purposes of the current inquiry is to describe the state of structuring organizational change in the health sector, within one State of Australia in the 1990s. Mergers, amalgamations, and acquisitions, leadership successions and organizational deaths are examples of researched events composed of a complex set of individual and organizational changes. The amalgamation at the centre of this research is due to particularly complex organizational changes. Therefore, an understanding of what has

come to be accepted as good practice in change management may aid the reader to better comprehend the intricate world of the “lived experience” of those in the organizations concerned at the heart of this research.

The literature on change management spans the distance between classical organization theory, with its ideas about organization behaviour as solid, ordered and predictable, and more recent academic discourses, which present an image of organizations as fragile, unpredictable and discontinuous. Fineman and Gabriel (1994) informed us that not only has the way of talking and writing about organizations changed, but that the meaning of the entity called organization has shifted. “We are now much more aware of the fragility of the activities which make up organizing, of the chaos which threatens even the best laid plans, and of the ambiguities of what was comfortably referred to as structure” (p. 376).

The development of major paradigms in organization theory can be seen as implicitly contributing to change theory, in so far as they have strongly influenced the conceptualization of organizational change (Nelson, 2002). Here we follow the concept of “paradigm” as defined by Capra (1988, cited in Darwin, Johnson & McAuley, 2002) who referred to it as “the totality of thoughts, perceptions, and values that forms a particular vision of reality, a vision that is the basis of the way society organizes itself”(p. 15). Nuttall (2000) placed the modern origins of organization theory in the early twentieth century following the work of theorists such as Weber (1946) on bureaucracy, and Frederick Taylor’s (1911) introduction of ‘scientific management’ in the USA (Nuttall, 2000, p. 229). From this perspective we are presented with a classical (or bureaucratic) paradigm where organizations are viewed as machines, and change is depicted as a rational

process centred around making jobs more efficient in light of assumptions of “economic man” (Nelson, 2002, p. 33).

With increasing pressures on industry, the attention of management theorists increasingly turned to the factors that influence human behaviour and motivation in the organization work setting. A human relations perspective emerged in the 1930s, originating in the growing discipline of psychology. The human relations paradigm emphasized individual behaviour within the social context of organizations, and depicted change in terms of its effects on individuals. This movement contributed to studies of implementing change, in that it was concerned with, for example, the behavioural aspects of overcoming resistance (Nelson, 2002). The human relations approach introduced the idea that human behaviour was complex and showed that there was not necessarily “one best way” to manage organizations (Nelson, 2002, p. 34). The idea that organizations should not necessarily be managed in the same way laid the foundations for what became known as contingency planning. Contingency theory, or strategic planning, holds that “a manager’s response will depend on identifying key circumstances in an organizational situation and selecting a solution to fit those characteristics” (Nelson, 2002, p. 34). Nelson (2002) pointed out that contingency theory came to be a fundamental principal of organizational theory. “Most research in organizational theory is a search for contingencies [where] investigators try to understand the relationships among variables so they can recommend which strategies and structures are appropriate in each situation” (Nelson, 2002).

A postmodern or post-bureaucratic approach began to emerge in the literature of management practice in the 1990s. The postmodern is usually seen as a culturally

innovative challenge to the ordered structures associated with modernism, a move away from modernism (or classicism) to “something explicitly eclectic and indeterminate” (Darwin, Johnson & McAuley, 2002, p. 151). Palmer and Hardy (2000) have pointed out that postmodernist writers such as Hassard (1994); Alvesson (1995) and Chia (1996), claimed that the postmodern organization had the flexibility to respond to an increasingly turbulent and chaotic external environment in contrast to the built-in inflexibility of modernism. In other words, the postmodern approach depicted organizational change as a “shift in response to new environmental pressures and, in so doing, conjur[es] up a new environment” (Palmer & Hardy, 2000, p. 267).

Approaches to the way in which researchers have viewed organizations have, moreover, been challenged by a growing movement towards the analysis of the cognitive side of organizational life, which has brought into focus the interpretive processes associated with organizational phenomena. The study of this dimension is gathering momentum in both theoretical and practitioner-oriented works (for example, Ford & Baccus, 1987 and Isabella & Ornstein, 1988, both cited in Isabella, 1990), as a complement to the study of the issues and relationships brought out by traditional approaches. The interpretive approach has focused on the cognitive logic that facilitates organizational members’ understanding and adjustment during change as they deal with a different construed reality, and set of interpretive tasks, within the predominant frame of reference which characterizes each stage. “Interpretations of key events evolve through a series of stages – anticipation, confirmation, culmination, and aftermath” (Isabella, 1990, p. 14).

The metaphor of culture added another paradigm to the field of organization management's conceptual kit, expanding the old implicit models of machines or organisms to include the new model of social process. "What is proposed is a dynamic and interactive model of organizing as a process that persists and changes over time" (Jelinek, Smircich & Hirsch, 1983). Organizations and organizing, like sophisticated moral reasoning, are, however, simply too complex to be well explained by simple dichotomies (like mechanistic versus organic organizations) or by monochromatic codes of reference (Jelinek, Smircich & Hirsch, 1983). Theorists such as Smircich (1983) recognized that "organizations are themselves culture-producing phenomena" (p. 344). Change is depicted in this paradigm as a process which is "conditioned by the nature of the human mind (which seeks to interpret or make sense) and the nature of the organization as a human artifact of the sense-making process" (Jelinek, Smircich & Hirsch, 1983, p. 338).

These major paradigms of change management will now be discussed in a little more detail, to assist with a clearer understanding of the possible processes underlying organizational change. It should be noted that a very extensive literature is available on the subject of change, and, remembering that a thesis is constrained by word length and completion time, the researcher made some hopefully judicious decisions about what to include, and therefore exclude, from this discussion. Nevertheless, it is hoped that this discussion will throw some light on the reasons for the difficulties experienced by the players in the case study at the centre of this research, as they struggled to come to terms with the results of a major paradigm shift in the way in which public health care reform was delivered in the 1990s in Victoria.

Classical Approaches

The legacy of the classical approaches to change management is the view that organizational change is something of an aberration. Inherent in the dominant classical models of change (for example, Lewin, 1951; Nadler & Tushman, 1989; Fuqua & Kurpius, 1993 and Kotter, 1995, all cited in Nelson, 2002) is an assumption of changing the organization to a more desirable final state. These models can be seen as “static” rather than reflecting any “dynamic nature” of change (Nelson, 2002, p. 37).

In classical organizational theory, change, if recognized at all, is viewed simply as altering one rule or procedure for another. In so far as change theory exists in classical theory, it consists of instituting new and different ways of organizing and directing work within its existing framework and assumptions. Classical theory thus fails to take into account the processes of how change should be achieved. It assumes that change can be implemented relatively easily, provided all the ramifications have been previously calculated. There are no “unknowns” in this view, just as there is perceived to be only “one best way” of managing (Nelson, 2002, p. 33). Change strategies, according to this view, can be constructed from quantitative scientific principles, and applied universally without regard for organizational circumstances. The underlying principle is that organizational rules are immutable, and their administration ensures efficiency. This view was derived from the paradigm of bureaucracy. Classical theory assumes that the normal state of organizational environments is one of stability. Hence change is abnormal, possibly reflecting an imperfect bureaucracy (Nelson, 2002).

Organizations confront a myriad of events to which they must respond. Traditional researchers view organizations' responses to events as entailing specific organizational and managerial actions and activities (Isabella, 1990). The study of organizations is usually defined by managerial prerogatives, while the organizational world is seen in terms of behavioural problems which should be fixed by a knowledgeable controlling elite. The analysis of traditional organizations is usually managerial, and takes for granted a competitive/capitalist value stance, highlighting discrete concepts such as motivation, leadership and communication. The reward for "more effective" or "getting it right" approaches to organizational issues is assumed to be more productive, more contented employees and more competitive organizations.

The Human Relations Approach

The softening of the pure scientific method, with its strong mechanistic overtones, led to the desire to include the “human element”. This led to the development of the human relations school of thought (Darwin, Johnson & McAuley, 2002), a movement that sought to humanize the machine and raise the profile of organizational culture as an element on which theory and practice should focus.

The human relations approach has been both a way of managing and a way of providing “a richer account of what is happening in organizations” (Darwin, Johnson & McAuley, 2002, p. 20). Human relations theory, commonly thought to stem from the Hawthorne studies (for example, Mayo, 1933 and Roethlisberger, Dickson & Wright, 1939, both cited in Nelson, 2002), recognized the role of self-protective behaviour, of the way people construct their own priorities and agendas, spend their time in brief, unscheduled conversations, and develop and maintain wide personal networks. The human relations perspective can also be seen as a more sophisticated form of management control than that offered by classical theory (Darwin, Johnson & McAuley, 2002).

Nelson (2002) concluded that, in large part, while the human relations school had been influential in explaining work behaviour, it had contributed little to our understanding of change “except in a peripheral sense” (p. 33). For example, boring and routine jobs have been criticized as having an adverse affect on performance (Walker & Guest, 1952 and Herzberg, 1968, both cited in Nelson, 2002), an affect which may have been alleviated by jobs that have variety, are meaningful, and preserve operator independence.

Human relations principles are also clearly implied in the model of Hackman and Oldham (1980, cited in Nelson, 2002), which linked job characteristics to psychological states that workers found satisfying (Nelson. 2002). In the human relations paradigm, the phenomenon of change, and the way in which the change process is managed, is, where it is approached at all, attended to as a matter of individual behaviour. In a positive sense, however, the paradigm does recognize that there is no “one best way” to manage change, as it appreciates that people do not all behave in the same way where change is concerned (Nelson, 2002, p. 34).

Postmodernist Approaches

More recent writers (for example, Alvesson, 1995; Cooper & Burrell; Hassard, 1994 and Parker; 1992, all cited in Palmer & Hardy, 2000) have reviewed approaches in which new ways of studying social phenomena are proposed, and which have shaken some of the fundamental tenets associated with traditional management theories. As Palmer and Hardy (2000) put it, postmodern approaches, raised “a number of important challenges to more conventional ways of thinking and, as such, provide a number of valuable insights to our understanding (p. 259). Whereas earlier approaches to organizational theory described organizations as stable entities with strict hierarchies of control and immutable rules, the postmodern approach portrayed organizations as loose, fluid, organic, and adhocratic entities. Where earlier approaches situated the organizational entity in a particular location at a particular point in time and history, postmodern theorists recognized that space and time are not natural phenomena but disciplinary practices that are imposed on us and which we accept without thinking (Palmer & Hardy, 2000).

To the postmodernist, “the organization is not one thing but many; they do not have clearly defined insides and outsides and because boundaries are uncertain and reversible, no organization, no description of it can ever be complete” (Palmer & Hardy, 2000, pp. 264-265). It should be noted, however, that just as the organization is not one thing, the body of work that makes up the postmodern is “slippery – there is no single postmodern theory or approach, but theories and approaches” (Palmer & Hardy, 2000, p. 259).

Whereas earlier approaches to change described the process as either abnormal, or as only affecting individuals but not organizational entities, the postmodern approach visualized change as a dynamic, rather than a static, phenomenon, leading to the observation that “further theoretical models that embrace the reality of changing environments *during* change need to be encouraged” (Nelson, 2002, p. 40).

Perhaps one of the more radical ideas that emanated from the postmodern approach, however, concerned the way in which notions of the individual, and issues of identity, were thought about and portrayed. Contrary to earlier, more traditional, or discipline specific theories (which are beyond the scope of this thesis), the postmodernist has conceptualized identity as fragile and not completely controlled by the individual who possesses it, and the individual as comprised of multiple and fragmented identities, so that there is no “true” self. People, it is said, do not exhibit personal characteristics; rather they perform them for, and in, a particular time and place. Palmer and Hardy (2000), for instance, defined identity as “a continuous process of narration where both the narrator and audience formulate, edit, applaud and refuse various elements of the constantly-produced narrative” (p. 275). This has implications for our understanding of, and work in, organizations, and for the case in point in this research.

The Interpretive Approach

Isabella (1990) introduced another perspective. Her research complemented the study of issues and relationships followed by traditional approaches, but brought into focus the interpretive processes associated with organizational phenomena. She noted that among the most challenging events to which organizations must respond are those that become the contexts for substantial change and adaptation. Nevertheless, these events were rarely static or contained within a discrete time frame, “unfolding over time, they demand continual adjustment and present unending challenge for all concerned” (p. 7).

Although many studies (for example, Katz & Kahn, 1978; Sonnenfeld, 1988; Harris & Sutton, 1986 and Sutton, 1987, all cited in Isabella, 1990) elaborated upon the concrete and observable behaviours and actions connected with these changes, few tried to identify and understand the interpretations and cognitions associated with them. As change unfolds, different assumptions and orientations are required at different times in the process. Isabella (1990) introduced the notion that managers involved in a change need to undergo an alteration of their cognitive structure that facilitates and supports the need to change, the process of changing, and the maintenance of what has been changed. The frame of reference - the perspective through which people view an event - shifts. Isabella suggested, furthermore, that understanding the cognitive basis for responding to change enhanced the effectiveness of organizational responses (Isabella, 1990).

The data from Isabella’s (1990) research revealed how managers collectively viewed events over time. Interpretations of key events evolve through a series of stages - anticipation,

confirmation, culmination and aftermath. A different construed reality, set of interpretive tasks, and predominant frame of reference, characterizes each stage. External events or “triggering events” appear to precipitate shifts that move individuals from one interpretive stage to another (p. 26). These events signal that a cognitive redefinition of a situation is required. The action of trigger events appears to parallel the process of change. Although various triggers in the unfolding of an event spark the shift from one interpretational stage to another, the personalizing experience of, and affective reaction to, triggering events keep the movement going. For example, as organizational members attempt to make sense of an event, they personalize it. “What will this mean to me?” and “How do I fit in?” are the affective reactions fueling the interpretive shift. Isabella’s research indicated that when an event or some aspect of it, becomes real - in the sense that it has directly affected or is about to directly affect people or their work - interpretive shifts gain momentum. In her research it is clear that the collective construed reality includes both elements of fact and feelings and emotional reactions (Isabella, 1990). The notion of a complex construed reality including shifts in both cognition and affect, was an important construct to keep in mind when interviewing the people included in the present research.

Isabella’s research goes beyond assertions that a significant amount of cognition is associated with change, by outlining the particular cognitive patterns accompanying the change process. Her model suggested that the fundamental stages of change - unfreezing, moving, freezing, as outlined by Lewin (1974, cited in Isabella, 1990) - are accompanied by the interpretive tasks of assembly, standardization, reconstruction and evaluation. In the case of change, an in-progress frame of reference gives way to a conventional frame of reference, which gives way to amended viewpoints that become an evaluative frame of

reference. Collective interpretations of key events move from unformed and tentative to well-constructed, well-processed viewpoints. “The implication of this progress is that the fullest understanding of an event may come from moving through all the interpretive stages” (p. 33). By so doing, individuals formulate an overall meaning for the event that is enriched by the stages that have come before. Thus, determining what an event means appears to be a process of going through a series of interpretive stages (Isabella, 1990). In the present research, interviewees’ (“managers”) stories reflected cognitive shifts, as well as a progression in collective interpretation and evaluation, as they recounted the events before, during and after the organizational amalgamation in which they were involved.

Besides having implications for future research into the relevance of her model for non-managers as well as for managers, Isabella’s inquiry raised the interesting question of how a convergence in collective frames of reference comes about. How is a dominant reality developed? Does it arise because individuals use the same cognitive processes (that is, go through the same stages) or because social interaction occurs? (Isabella, 1990). At this point in time it is appropriate to examine the literature about organizations as cultures.

The Cultural Approach to Organization Theory

It should be noted that, although the concept of organizational culture is much talked about, exactly what it is, is a matter of debate (Langan-Fox & Tan, 1997; Lee & Barnett, 1997). The differences in approach derive from differences in basic assumptions that are made, not only about “culture”, but about “organizations” per se. Smircich (1983) outlined many of the ways that culture has been understood, including as an instrument serving human needs; an adaptive-regulatory mechanism uniting people within social structures; a system of shared cognitions; a system of shared meanings and symbols, and a projection of the unconscious. Organisms may be thought of as social instruments designed to accomplish tasks; adaptive organisms in a process of exchange with the environment; systems of knowledge; patterns of symbolic discourse, or forms and practices that express unconscious processes. More recently culture has been described as “temporary webs of individuals loosely connected by the issues they are interested in [and as] organizational sense making” (Choo, 1998, p. 102; 103).

Arguably, when we talk about culture we are referring to “the pattern of development reflected in a society’s system of knowledge, ideology, values laws, and day-to-day ritual” (Morgan, 1986, p. 112). When culture is viewed from a functionalist perspective, the focus is “on the role of cultural objects in organizational maintenance” (Lee & Barnett, 1997, p. 395). That is, it is seen as an organizational variable, such as the organizational structure, rewards system, training and development program, or technological system, for example. As such it can be moulded by management to suit current purposes. In other words, culture is seen as one tool among many to be “cultivated by management for the purpose of control

and legitimatization of activity” (Smircich, 1983, p. 346). In the case of the current research, it was noted that the Alpha Hospital was “an organization which worked hard and promoted heroes” (the Interviews). The cultural tool in this instance could be interpreted as “excellence which was encouraged”. In the case of the Beta Hospital, “nice things were done for people although heroism was not encouraged” (the Interviews).

There is another view that favours the notion that culture is something an organization *is* (Smircich, 1983; Morgan, 1986; Hatch, 1997). That is, culture is not held to have an objective existence apart from human beings, but is instead “a socially constructed reality [made up of] artifacts, symbols, norms, values, beliefs, assumptions and physical, behavioural and linguistic symbols interrelated in a web of interwoven meanings accessible to all members of the culture” (Hatch, 1997, p. 236). In a later chapter here there is reference made by the interviewees to a cultural artifact, or symbol, existing at the Beta Hospital in the form of a hospital logo. Although within this view the nature of culture can be understood as cognitive, symbolic, structured or psychodynamic, all these understandings depend on the context in which the artifacts, symbols, behaviours and so forth, are to be found (Hatch, 1997). It is the socially constructed and changing reality, that is, the context, that becomes apparent through the narrative methodology employed in the current research.

Mirvis and Marks (1992) believed that “how a company goes about doing business is indicative of its culture” (p. 170). It should be noted that company cultures provide answers to people about how their organization adapts to its environment, and provides for their material and psychological needs. Culture is usually defined as the social or

normative glue that holds the organization together (Smircich, 1983) As such, culture connects the formal organization, including company policy, strategy, and structure, with the informal organization taken-for-granted ways people interact, think and go about their everyday behaviour. Culture expresses the values or social ideals and the beliefs that organization members come to share and which are manifested by symbolic devices such as myths, rituals and stories. The later chapter here that shares the stories of the “lived experience” of the participants in the amalgamation will highlight these aspects.

Bright (2000) noted that in the case of mergers and acquisitions, culture exerts a tremendously powerful force that can effect the outcome of the merger in ways which are both subtle and disruptive. “Culture is both the set of rules which binds us together, and the sense of difference which keeps us apart” (p. 6). The negative capacity inherent in mergers routinely emerges as a more dominant constraint than the positive effect of expected performance improvements. However, Bright cautions us in that it does not follow because a strong internal culture is linked to resistance to change, that the change managers should work to weaken or fracture the culture in order to facilitate change. “This merely results in greater alienation and withdrawal” (Bright, 2000, p. 11).

Clearly, culture is not just one simple variable among many, but is, rather, “an active, living phenomenon through which people create and recreate the worlds in which they live” (Morgan, 1986, 131), but could be generally said to be resistant to change; be taken for granted and less consciously held; derive its meaning from the organizational members, and incorporate sets of shared understandings (Langan-Fox & Tan, 1997); provide its members with socially legitimate patterns of behaviour, and a hierarchical motivational structure

linking their identity to culturally relevant roles, and finally, provide a symbolically integrated framework that regulates social interaction (Lee & Barnett, 1997). Given its complexity and embeddedness within organizations, it should be given due consideration whenever there is an attempt to carry out a change process within an organization, even if the proposed change affects only a small part of the organization, let alone a major cultural shift of the kind required in the hospital amalgamation which is the subject of the current research.

Theoretical Perspectives on Merger Management

Introductory Remarks

Mirvis and Marks (1992) reviewed the approaches already outlined, within the context of a “merger or acquisition” (p. 25). They suggested that no one single theory could explain the varied and complex dynamics of human and organizational behaviour during a merger or an acquisition. This view is in accord with Nelson (2002) who made “no attempt to argue the superiority of one particular model over others”. Instead, Nelson adopted “a pluralistic position so that the merits of differing theoretical positions can be explored” (p. 32). Likewise, Mirvis and Marks (1992) viewed merger management as steeped in an eclectic but complementary set of theories deriving from a variety of perspectives. This approach would appear to have merit with regard to the current research, where the view is adopted that, “the competing merits of [each theoretical position] are of less interest than the contribution each makes to the understanding of the context and processes of change” (Nelson, 2002, p. 32).

The Macquarie Dictionary (1991) defines an amalgamation as “a merger of two or more companies” (p. 51). The same source defines a merger as “any combination of two or more business enterprises into a single enterprise” (p. 114). While the two terms are often referred to as separate items in the change management literature, the definitions given here suggest that the meaning they convey is analagous. In this research the terms amalgamation and merger, acquisition and combination, will be used interchangeably, and their meanings assumed to be the same.

Cultural Approach

One approach within the framework suggested by Mirvis and Marks (1992) is that of culture. This approach enables us to understand that each of the institutions involved in a combination or a merger has its own definition of rationality, politics and appropriate behaviour. Companies involved in a merger have unique histories, folklore, and leaders as well as products, markets, and ways of running the business. People are generally proud of their company traditions and cultures. It is part of who they are and what they know succeeds. When a merger brings together two companies, a natural reaction is for people to compare their own group, for example a division or a department, with “the other” and make distinctions between them. Often this precipitates a clash of cultures.

A clash of organizational cultures resulting from an amalgamation was evident in the present study, where the unique histories and organizational structures of the hospitals involved were contributing to the perception that there were two disparate cultures. This was often clearly expressed by the interviewees from both hospital campuses, and was usually pejorative where the other party was concerned. For example, the opinions which were expressed by the two groups of interviewees comparing one hospital with the other were that while in one, people were “friendly”, more “caring and sharing”, and “less bureaucratic”, people who had come from the other hospital were “a bit snobby” and “more hierarchical”. “They thought they were the best” (the Interviews).

Mirvis and Marks (1992) liken corporate culture to “breathing. You don’t really think about it until it is threatened” (p. 170). People frequently take their company cultures for

granted until a change, like a merger, creates fears that desired aspects of their way of life may be lost. Managers come to revalue key aspects of their company culture as they contemplate a combination. Implicit knowledge of how their company works, and how policies and systems sustain the firm, come to be explicit as they compare their ways with the other side's and reflect on what will be lost. This often leads people to defend their own culture during a merger or acquisition and to attack the other side (Mirvis & Marks, 1992).

Sathe (1983) also examined the subtle but pervasive role of culture in organizational life. His thrust is that although for many people culture remains an elusive and fuzzy concept, it has important implications for managerial action. Sathe conceded that culture "is the set of important understandings (often unstated) that members of a community share in common" (p. 6). In addition, in describing culture, we are talking about two typical types of shared understandings: beliefs and values. Our beliefs are basic assumptions about the world and how it works. Our values are also basic assumptions, but ones with an "ought to" implicit in them. Beliefs and values that have been held for a long time without being violated or challenged may become so much taken for granted that people are no longer aware of them. This is why organizational members frequently fail to realize what a profound influence culture has on them (Sathe, 1983).

Managers interested in producing culture change must understand and intervene in each of the basic processes that cause culture to perpetuate itself. Culture is communicated via both "explicit" and "implicit" forms. The latter include "rituals, ceremonies, stories, metaphors, heroes, logos, decor, dress, and other symbolic forms of communication"

(Sathe, 1983, p. 19). Both explicit and implicit communications must be relied on to nullify external justifications for the new behaviour (for example, financial incentives), and to persuade people to adopt new cultural beliefs and values. Sathe recommended that this is best achieved through a combination of gentle incentives to engage in the new behaviour, and compelling persuasion.

“What can be done to sensitize managers to the clash of cultures and prepare them to manage its consequences?” (Mirvis & Marks, 1992, p. 177). This can begin with the recognition that the two sides enter a merger with distinct histories, styles and reputations. Cultural differences between combining organizations need to be recognized, rather than ignored or denied. Emphasis needs to be placed on processes of acculturation, wherein people participate in events and gain experiences that alter fundamental beliefs about themselves, about other people, and about how things work. Combination scripts which delineate the roles of the two combining institutions and their intention toward one another, and to the type and character of their integration, can directly influence the cultural consequences for one or both institutions. What impressed Mirvis and Marks (1992) in their work as management consultants was “how the very best merger managers transcend seemingly preordained scripts and lead their people through a symbolic death and rebirth” (p. 28).

We can draw on one demonstration of a good transcendence in the earlier “forced merger” of the Alpha Hospital and the Gamma Hospital. One interviewee described this event as “very hard” for the people at the Gamma Hospital. Eventually they came to see it as a “good thing, but this took some years and a lot of new developments (including a new

infrastructure) to bring them around”. However, what really counted was that the merger was handled very well in that “people were allowed to mourn for what they were losing”. For example, “there was a yearly review where staff acted out their feelings through irony. In the first year post-merger, one thing they did was to shoot off a cannon which was directed at the Alpha Hospital. Fifty percent of the skits in the second year post-merger were about the merger. By the third year post-merger there were none”. The interviewee saw this as a sign of health for the people at the Gamma Hospital campus. By this time those people who could not accept the change (a small group) had finally left. “It was important to allow people to grieve and not to comment. Senior people from the Alpha hospital went to the reviews and handled it very well. There were no comments, which allowed the humour to be maintained, and so it went well” (the Interviews).

Psychological Approach

Mirvis and Marks (1992) included psychology in their model of change management. They defined this as a perspective which “posits that strategies and plans are constantly being informed and revised based on managers’ own emotional states and those of the people around them” (p. 26). Moves and countermoves can be understood as reactions to threat, loss, or perceived injustice. Terry and Callan (1997) looked at a number of variables contributing to a stress-coping model of employee adjustment to organizational change. Variables investigated included the characteristics of the change situation, employees’ appraisals of the situation, their coping strategies and the extent of their personal resources. Data were collected from one hundred and forty middle managers and supervisors involved in a large-scale public sector integration, incorporating a large-scale reorganization occurring as a consequence of the integration. Middle managers were viewed as typically

responsible for implementing the organizational changes. They were also seen as vulnerable to the downsizing that often occurs during a period of change. The integration was sudden, and directed primarily by political imperatives towards producing savings and increased efficiency. All these features are resonant of the situation explored in the present study.

It was proposed by Terry and Callan (1997) that managers would appraise the event more negatively, report more disruption and change as a consequence of the change, and use more ineffective coping strategies (because of heightened levels of stress) than supervisors. Terry and Callan's work suggested that there was some evidence to indicate that the experience of organizational change is different for managers and supervisors. Levels of threat were higher for managers than for supervisors, but there was no difference between the groups of employees in terms of adjustment. In the current research, this work has implications for the importance of considering employee status as a variable that impacts on the experience, appraisal, and coping strategies of the people who are experiencing survivor symptoms in such situations.

Transitions offers another approach for looking at change management from a psycho-social perspective (for example, Bridges & Mitchell, 2000; Dupuis, Boucher & Clavel, 1996; Frankel, 1998; Williams, 2001). An important aspect of change involves the ability of the workteam members to negotiate transitions. While most organizational change theories and practices focus on motivation, performance and organizational agendas for change, less attention has been given to psycho-social contexts for individuals. Williams (2001) pointed out that change strategies can either impede or enhance the natural

psychological process of transition that enables individuals to adapt to change and transform their lives. Arguably, to date, there has been little understanding within corporate human resourcing policies of the human potential to adapt creatively to trauma and change, and of opportunities for self-healing and personal and career development that occur during the transition process. “The transition process offers a template for understanding the stages of personal change. We cannot avoid this process but we can learn how to make the best of it for our work and personal life” (Williams, 2001, p. 1).

Bridges and Mitchell (2000) reminded us that there was a fundamental difference between change and transition; we must avoid mistaking one for the other. They query what it is that happens when people do not make the changes that need to be made, when deadlines are missed, costs run over budget, and valuable workers get so frustrated that when a headhunter calls, they jump ship. The details of the intended change are not the issue. What happens, happens because transition occurred in the course of every attempt at change. Transition is the state that change puts people into. The change is external (the different policy, practice, or structure that the leader is trying to bring about), while transition is internal (a psychological reorientation that people have to go through before the change can work). Dupuis, Boucher and Clavel (1996) noted a clear parallel with the mourning process as presented by Kubler-Ross (1969). This feature was not lost on some interviewees in the research who commented that, “the biggest thing in the amalgamation is the grieving process. It is the Kubler-Ross model - it includes all the stages. People are in different stages all at the same time. Denial, there are still people in denial. They’re stuck” (the Interviews).

The Kubler-Ross model has five stages of grieving: denial; anger; bargaining; depression, including feelings of guilt; acceptance. This ordering is not axiomatic, and stages can be skipped or experienced in a different sequence (Kubler-Ross, 1969). A first requirement of transition is that people have to let go of the way that things, and the way that they themselves, used to be. Bridges and Mitchell (2000) referred to this phase as “saying goodbye” (p. 2). You are asking people here to let go of what feels to them like their whole world of experience, their sense of identity. What in theory may look like a simple effort to merge two work groups, in practice means that people no longer work with their friends or report to people whose priorities they understand. In the present study, one interviewee, formerly a director of nursing on one hospital campus, was expected to assist with the downsizing that resulted from the concentration of hospital wards following the amalgamation. She reported on the distrust and anger felt by people as a corollary of the process. “The teams broke down in the wards. All had been reshuffled and they had to learn to trust each other as co-workers again and with what each team could contribute. People were very suspicious of any industrial moves. Even positive implementation was regarded with suspicion. For example, on the eighth floor there was an attempt to amalgamate two small wards and offset a position. The intention was to create a new position which would have helped with the pre-admission of patients. Everybody would have benefitted and no sackings would have occurred, but because of the fear of change it was taken to the union and defeated. The staff was just so fearful of change, which had previously affected them so adversely, they came up with rationalizations such as, a larger ward would diminish patient care. Although this was patently not the case, the staff was unable to talk about what was really going on with them” (the Interviews). It is not

difficult to discern elements of denial, anger and depression from the Kubler-Ross (1969) model in this example.

This manager realized “that the change was probably necessary, but if it happened again, I would never advise for it [the amalgamation] to be done in this way”. For her own part, she “missed the interaction with a group that I trusted. Now I have nobody, not one colleague in the organization a year later who I can confide in and say, for example, I’ve had a shit of a day. The camaraderie is gone. If I don’t have it, then the staff hasn’t got it either” (the Interviews). Clearly, this manager was not immune to the effects of transition, including depression, in terms of her own role description.

“The trouble is, most leaders imagine that transition is automatic - that it occurs simply because the change is happening. But it doesn’t” (Bridges & Mitchell, 2000, p.1). With clear relevance to the present study, these researchers noted that just because two companies (or hospitals or law firms) are now fully “merged”, this does not mean that they operate as one or that envisioned cost savings will be realized. Transition happens much more slowly than change, and it requires that people undergo three separate processes (saying goodbye; shifting into neutral; moving forward), all of which “are upsetting” (Bridges & Mitchell, 2000, p. 2).

Even after people have let go of their old ways, they find themselves unable to start anew. They are entering the in-between state, or neutral zone, that characterizes the second phase of transition, where there is so much uncertainty and confusion that simply coping with it takes most of people’s energy (Bridges & Mitchell, 2000). This neutral zone is

uncomfortable (but not wasted, for that is where the creativity and energy of transition are found), so people are driven to get out of it. Some people try to rush ahead into some new situation, while others try to back-pedal and retreat into the past. Bridges and Mitchell (2000) felt that a major merger may take two years to emerge from the neutral zone. The change can continue forward on something close to its own schedule while the transition is being attended to, but if the transition is not dealt with, “the change may collapse” (p. 2).

The third phase of transition, the “moving forward” phase, requires people to begin behaving in a new way and that can be disconcerting. It puts one’s sense of competence and value at risk. Especially in organizations that have a history of punishing mistakes, people hang back during this final phase of transition, waiting to see how others are going to handle the new beginning. All those who experience major transitions have to let go of elements of their past before they can finally come to terms with their new reality. Organizations can help or hinder this process. When this is done successfully, individuals take on a new lease of life, acting confidently and creatively (Bridges & Mitchell, 2000).

Transition must be managed effectively in order to allow change to take place as smoothly as possible. In dealing with the difficult realities of downsizing, managers’ responsibilities increase considerably, and interpersonal communication becomes an essential tool. Employees “need to trust their leaders’ competence, credibility and motives” (Williams, 1999, p. 610). Unfortunately, most leaders come from backgrounds where technical, financial, or operational skills were paramount, and those skills provide little help when it comes to leading people through transition. Bridges and Mitchell (2000) stress the importance of “a trusted colleague, confidant, coach, or consultant [who] can offer valuable counsel to the leader” (p. 3), so that he or she can develop new skills and behaviours geared

specifically “to the needs of the unique time and circumstances in which [that] person leads” (p, 4).

Strategic Management Approach

Mirvis and Marks, 1992) also looked at change management from a strategic management approach. This perspective assumes that managers are “*information processors* who scan their environment to identify problems and opportunities, formulate strategies and tactics to address them, and then plan activities and organize their people to achieve desired results” (p. 25). These researchers noted that strategy implementation was based on the assumption that top-down leadership, goal-setting, feedback, and the judicious application of rewards effectively guide behaviour in organizations (Mirvis & Marks,1992). Barry and Elms (1997) also reviewed the field of strategic planning, and they agreed that over the last two decades the accepted view was that “planning could do no wrong” (p. 429), and that this was endorsed by “planning-as-panacea statements” such as “the top management of any profit-seeking organization is delinquent or grossly negligent if they do not engage in formal, integrated, long-range planning” (p. 439). Bright (2000) noted, with some irony, that where scenario planning had been linked to change management initiatives in Australia, traditionally these “begin with structure and end with staffing levels” (p. 8).

Unfortunately, strategic planning can be reactive in its response to situations like a merger. Mirvis and Marks (1992) reported that a merger or acquisition “generates its own turbulence that produces stress, threat and emotional disequilibria” (p. 11). Successful outcomes depend on the efforts of many people who have to work long hours; contend with

great uncertainty; handle conflict and upset; make important decisions; and get along with people whom they do not know, may not trust, and with whom they may be in competition. As will become evident from interviewee reports, the case study being explored in this thesis provides a good example of this.

Other key writers in the area of strategic planning (Barry & Elms, 1997; Bright, 2000; Emden, 1998a, 1998b) have expressed interest in a narrativist redefinition of strategic planning. Barry and Elms (1997), for example, argued basically that “from a practitioner’s viewpoint, the narrativist stance can encourage people to explore strategic issues in more meaningful ways” (p. 430). Referral to classical archetypal figures and motifs such as the hero, the martyr, and the wanderer, might provide a deeper sense of meaning and purpose than can be achieved through, for example, spreadsheet modelling. A narrative view of strategy stresses how language is used to construe meaning; consequently it explores ways in which organizational stakeholders create a discourse of direction to understand and influence one another’s actions. Writers using a narrative approach assume that tellings of strategy fundamentally influence strategic choice and direction, often in unconscious ways (Barry & Elms, 1997). Strategic effectiveness from a narrative perspective is intimately tied to acceptance, approval and adoption of change. Further, this approach asks us to conceptualize success, to view success as a social construction that is tied to specific cultural beliefs and practices. Bright (2000) argued for scenarios as a form of strategic planning. Scenarios present an opportunity to develop creative communication processes which are interactive and based on story telling, which, in turn, allows the discussion of multiple issues at multiple levels via narrative methodologies. “Scenarios, if they focus forcefully and credibly on organizational culture - the driving, underpinning forces that

create behaviour - give the strategist a powerful tool to describe behaviour, values, process, interaction and performance” (Bright, 2000, p. 3). Many scenario planning approaches pass quickly over contentious issues of culture in favour of a definition of the business idea and an environmental scan. Bright (2000) recommended instead for strategists, that they “investigate organizational culture with the enthusiasm of the anthropologist or linguist, it will have a major impact on the success or failure of [their] program” (p. 14).

Managing the Merger. Some Comments Made

Mirvis and Marks (1992) explored what needed to be done to manage a merger successfully. They report that when merging commences, managers and employees are initially preoccupied with impending change, and vigilant to signs of what it all means for themselves and their work areas. “They get nervous and edgy, cloy together with their peers, and get clammy when facing superiors and subordinates - all the time sorting themselves out as possible winners, losers, or survivors” (Mirvis & Marks, 1992, p. 11).

The perception that there were “winners and losers” was a strong theme in the present study. “There was an atmosphere of winners and losers. In the process of change, certain people will promote their own causes. The perception is of “B” team people winning the race at the senior executive level. All co-operation went out the window - a “do or die” situation’. It was a fight to the death” (the Interviews). People’s first reaction is to think of their own interests. At this stage people generally develop a story about the merger. Based on sketchy information, the story is often a mixture of fact and fantasy. Fear is commonplace, fuelled by the rumour mill. As was observed by Isabella (1992) who looked

at how interpretations are constructed in order to understand key organizational events, “the construed reality at this stage is composed of both rumours and disconnected pieces of information” (p. 16).

Top managers themselves are not immune to “merger madness”. It can fill normally confident executives with self-doubt and cause even battle-tested leaders to “shoot themselves in the foot”. “The simple truth is that when called upon to be at their best during a merger, many top executives are at their worst. They fail to understand what is happening to themselves or their people. Their built-in bias for action bowls over careful planning and preparation. And their drive for results subverts the very processes of problem solving and commitment building necessary to achieve them” (Mirvis & Marks, 1992, p. 12). Bright (2000) agreed when he commented that “it is a truism of M & A [merger and acquisition] activities that while we assume the key strengths of the merging organizations will come to the fore, the reverse is often the case” (p. 10).

In the first several months after a deal, or organizational change, such as an amalgamation, merger-related dynamics can set the newly combined enterprise on the wrong course. Stressful feelings and rumormongering ferment on both sides; conflicts over who should lead and staff the newly combined departments erupt. Stereotyping and misunderstanding based on differences between the two corporation cultures reinforce the battle lines. For example, in the present research, in the early stages of the amalgamation, there was a perception by the Beta Hospital that “there was a gnashing of teeth at the Alpha Hospital - petitions, submissions, howling and so forth. There was no belief that it would be a fifty/fifty thing. The fear [expressed by people at the Beta Hospital] was that the Alpha

Hospital would take over the Beta Hospital wholesale”. Meanwhile, at the Alpha Hospital there was a perception that “the influence of the Alpha Hospital seems to have been marginalized at the management level within the newly amalgamated hospital” (the Interviews).

Isabella (1992) suggested that managers’ interpretations of the event they are experiencing at this early stage after a merger can be described “as using a conventional frame of reference” (p. 17). Traditional and routine explanations of what an event will personally mean to people characterize corrective interpretations at this stage. “Interpretations at this stage provide no new or creative insights but primarily reflect understandings that worked or are believed to have worked in the past - presumptions about what will be, based on what has been” (Isabella, 1992, p. 17). Conventional explanations, for example, “might describe how an acquiring company completely alters the character of an acquired company, how a new president brings in favoured staff to replace the previous personnel, or how reorganizations bring job loss” (Isabella, 1992, p. 22). Then, after management has announced the staffing plans, published its decisions on structure and systems, a second unsettling wave rolls through the organization. “This phase of post-merger trauma is fed by early tensions and still unresolved conflicts - back-burner issues now ready to boil” (Marks & Mirvis, 1992, p. 20). In the current research this period was described by the interviewees. “People who were left who weren’t going for positions. They were mainly preoccupied with how they were going to work in future in the new regime. While the winners of positions in the new organization were initially happy, there was not a lot of time for them to enjoy their success. Then, they had to look at what was happening with

their role and their work, for example, working with a new team of people; or working with a new manager who had different objectives” (the Interviews).

In the post-merger period, workers are no longer so worried about future employment but instead about the scope of new tasks and responsibilities, the personalities of their new bosses and co-workers and where they stand in the new organization. Workteam leaders and members have a multitude of questions about one another and their situation. They also have to tackle a daunting set of integration tasks, at the same time as they continue to serve clients, process information, and do all the other things necessary to keep the organization going. Experience shows that members are still going through a psychological reorientation from the “old” to the “new” and the new team as a whole is not yet ready to move forward (Marks & Mirvis, 1992). Isabella (1992) talked about this stage, in which the managers in her study “expressed a sense of confusion about the old not working or a feeling of being perplexed about new behaviours replacing old ones” (p. 23). This resonates with the shift from the second to the third phase of transition, as Bridges and Mitchell (2000) outlined.

David Noer (1993) talked about the winners or “survivors” of organizational change following a norm of denying and blocking. This “psychic numbing [psychological reorientation] is also commonly found in survivors of other forms of trauma” (p. 11). He noted that while managers have the challenge of keeping the system together during a time of fundamental change, the mismatch that comes from the old strategies played out in the new environment “does not feel right from either the organizational or the individual perspective” (Noer, 1993, p, 185). In the research there was comment that “people were in

a sort of shock. There was a new story every other day which had to be digested. After the amalgamation had gone through, people at the Alpha were shell-shocked. You couldn't go near them" (the Interviews).

During this stage in the transition, employees mythologize their old jobs. They forget the nettlesome parts of their former work and remember only the pleasant aspects. "There is still a lot of looking back into the past and hoping it will come back. The staff reminisces a lot about what was. This activity is still part of the grieving process" (the Interviews). Mirvis and Marks (1992) described this as "reactions to loss; the loss of old friendships, familiar stimuli, and comfortable routines" (p. 21). Employees try to hold on to their old work habits and affiliations. This makes it difficult for employees to focus on new job requirements. To complicate matters further, people may also mourn the loss of fellow workers and suffer from survivor guilt. "Survivors [of organizational restructuring] suffer long-lasting symptoms that are in many ways similar to the symptoms of other survivors" (Noer, 1993, p. 34). Lingering anger, a generalized mistrust of higher management and a palpable loss of idealism all lead to suspicion and cynicism. The research carried out by Noer(1993) demonstrated that these symptoms were still pronounced in individuals five years after they were first clinically observed. In fact, some were more pronounced and deep-rooted than ever (Dupuis, Boucher & Clavel, 1996). In the present research, as well, there was pejorative comment about the Chairman of the new network. "He [the Chairman] was politically well-connected but not very smart and didn't realize it. He was very arrogant and dull. Likewise, the new CEO of the amalgamated medical centre was intellectually OK, but he had no people skills. He is insecure. Moreover, he has never been a CEO before" (the Interviews). There are employees who, for one reason or another,

feel they have been “jerked around” by the transition process. These employees might conclude that “their managers are incompetent or insensitive”, or that “something is going on behind their backs” (Mirvis and Marks, 1992, p. 228). This makes it even harder for management to reenlist people into a new work unit.

The concept of survivor syndrome will be examined closely in the next section of the thesis, but it needs to be acknowledged that “survivor symptoms in organizations is a major obstacle to organizational change” (Dupuis, Boucher & Clavel, 1996, p. 5). When we consider the consequences of mass layoffs or large-scale organizational restructuring, the reactions and feelings of managers are hardly the first things that spring to mind. “In fact, managers are usually perceived as hatchet men” (Dupuis, Boucher & Clavel, 1996, p. 7). Nevertheless, having to implement an organizational restructuring is by no means a painless process and we must acknowledge that managers share in the suffering. Managers who find themselves in these crisis situations experience feelings of fear, isolation and guilt. Examining this issue provides the motivation for the current research.

It is quite evident that managers are not immune to survivor syndrome. Indeed, they need to confront the possibility that they too can fall victim to it. Frankel (1998) wondered “if humans have a biological predisposition to react negatively to involuntary transitions” (p. 1). Frankel (1998) observed that humans are both blessed and cursed with an intellectual capacity to scrutinize their lives. People form expectations about their personal lives, for example, expectations about their children, as well as about their working lives where the tendency is for previously successful managers, having internalized the belief (thus the expectation) that their success is a function of competence and hard work, blame

themselves when faced with seeming failure. Change leaders will continue to confront the behavioural by-products of an interaction between the changes they champion and “the mindware of the people affected by those changes” (Frankel, 1998, p. 2). Change leaders thus need to be aware that managers and employees are likely to internalize blame for the circumstances that lead to the need for change, because change conflicts directly with managers deeply held expectations, or beliefs, about how things should be done.

If politics played a part in top-level appointments, politics will likely intrude (or be seen to intrude) on other lower level selections. “The amalgamation was economically motivated but the process was politically driven. Technically, with the amalgamation, it should have been the ‘best process’ that determined who was chosen. But staff perceived that what worked was whoever yelled the loudest” (the Interviews). Managers have to weigh loyalty to their people against criteria such as merit, the need to balance the staff from both sides, and many other considerations. Next, decisions on budgets, space, resources and the like become prominent. “Finally, there is the matter of writing new job descriptions and getting people focused on their new roles” (Marks and Mirvis, p. 21-22, 1992).

Leaders of new work units have to establish a new *modus operandi*. Making a fresh start is, however, complicated by the clash of cultures. By their very nature, mergers produce an “us versus them” relationship, exacerbated by the natural tendency for people to exaggerate the differences between their two organizations. Workers who survive a merger often feel threatened by the new system of beliefs and values regarding the best way to get things done. New performance standards and methods often feel foreign. People who are learning to adjust to new ways of doing things are more dependent on others and less able

to solve their own problems. Marks and Mirvis (1992) queried what it takes to build a new unifying work culture among a unit or group of workers whose members come from different organizational cultures. In terms of the current research an important first step might have been to recognize symptoms of survivor syndrome as well as identifying cultural differences. This might have been achieved by talking to the organizational members involved in the merger before the event. They had very clear ideas about the cultural divide which existed as demonstrated by the material provided in the interviews.

Isabella (1992) suggested that symbolism appeared to play an important role at this stage in facilitating the learning of new behaviours, norms and schema, as well as in shifting the culture of the organization. Since the established routine has been disrupted, managers search their surroundings for clues from which to derive new meaning, or reconfirm old understandings, and symbols provide that valuable information. “Therefore, the interpretive task at this stage is reconstruction. Managers are actively reconstructing their environment, deciding what to retain and what to alter” (Isabella, 1992, p. 25). As was demonstrated by the interviewees, this process of reconstruction can be enhanced by symbolic activities allowing survivors to express their negative feelings, such as the Gamma Hospital reviews and the cannon fired at the Alpha Hospital.

Marks and Mirvis (1992) identified the issue of team building as an issue for managers who are responsible for guiding post-merger development. Biggerstaff and Syre (1991) examined teamwork between leaders and employees. This is important in achieving progress within a hospital environment. Their prescription is that initially team leaders should call together the members of the team and ask for their help. This is because “involving team members in decision making and problem solving will help them identify

more closely with the goals of the project or program and to develop more concern about its success” (Biggerstaff & Syre, 1991, p. 35). As a corollary, this will allow status differentials among the members of the team and leaders to break down, enabling more open and honest communication. In the research, the pre-amalgamation CEO of the Beta Hospital spoke about the process that was put into place when the Beta Hospital was being integrated into the State system. “As one way of dealing with integration, we introduced things like a better business planning process and quality improvement plans”. His assessment at the time was “that it wasn’t completely successful, but there was a degree of meeting in the middle. Moreover, instead of driving the business plan from the top down, we got local work groups to start putting up what they would like in a business plan. It was driven from the bottom up. The direction of the strategy was very much continuous quality improvement with team-based efforts which was good at getting staff working together on particular projects. It’s a great way of managing irrespective of whether you are going through major changes or not”. (the Interviews).

Organizational leaders have to “sell” employees on the near-term merits and long-term advantages of being part of the new organization. David Noer (1993) referred to this as “from paternalistic to empowering management behaviour” (p. 166).

He defined leadership in terms of process. “Leaders are meaning makers; they structure a confusing and ambiguous environment toward some unifying purpose. The basic task of new-paradigm leadership is making meaning” (p. 190). Noer (1993) said that both employers and employees find themselves at an interesting place. An exciting and “potentially liberating” part of new employment is that employees can have the

opportunity to develop the skills and perspectives to take care of themselves (p. 167). Organizations can facilitate this by encouraging autonomy, for example, “letting employees plan their own careers” (p. 167). People can learn or relearn needed skills, and organizations must foster this learning. Leaders must shift behaviour from motivational strategies that promote dependence (the old paradigm of employment) to strategies that promote independence (the new paradigm of employment). In the new employment contract where the employee engages in short-term good work, and the organization provides monetary compensation, the leader puts himself or herself into a helping (non-dependent) relationship with employees (Noer, 1993).

Following a developmental model, Tuckman (1965) offered forming, storming, norming, performing and adjourning. Carter; 2001; Kennedy & Murphy, 2001; Madden, 2003 and Wing, 2001 all referred to Tuckman’s (1965) framework as “the stages that you can expect to go through” (Madden, 2003, p. 15), as the new work team and group leader together move from “tentativeness, into conflict, and then into conflict avoidance” (Wing, 2001, p. 68). *Forming*: In the forming stage, individuals are trying to get to know each other and the [restructured] organization. A commitment to the team effort has not yet been formed. Leaders provide direction and outline expectations. *Storming*: Storming, is a rocky stage where team members may challenge the leader and each other. Madden (2003) put it succinctly. “Storming was not fun” (p. 16). The job of the leader is to coach team members on how to manage conflict and focus on goals. *Norming*: After individuals have worked through conflicts, things start to gel in the norming stage. People appreciate their differences and work together. The leader now serves as a facilitator, offering encouragement and guidance. *Performing*: Ideally, in the performing stage the group is

finally fully functional, able to manage their relationships, and work toward shared goals. Team members feel accepted and communicate openly with the leader. The leader focuses on delegating responsibilities and identifying when the team is moving into a different stage (Carter, 2001). Writing in terms of a “start-up operation” Madden (20003) observed that “performing is a stage that very few start-ups ever reach” (p. 16).

Adjourning: Providing the performing stage is successfully negotiated, Tuckman’s (1965) model identifies an additional stage of team development (Wing, 2001). In this stage the goal is to adjourn the group; to formally close the team’s work in a way that celebrates both individual and team success. Some “ending” rituals are suggested, for example, talking about what each person contributed to the team, or choosing some activities that everyone enjoys. This is a time to encourage the team to celebrate, reflect and ready themselves for new challenges. Asking a team for their ideas about how and when to adjourn will assure that the team’s needs are met as the team adjourns (Wing, 2001).

Winchell (2001) recognized the effectiveness of using work groups or teams properly but felt that they are “rarely properly used during restructuring or downsizing initiatives” (p. 261). Impediments to good outcomes include questionable normative organizational behaviour and the tendency for supervisors to opt for the immediate, short-term solution, thereby creating additional barriers to effective team utilization.

Winchell (2001) believed that the team’s effectiveness in supporting change requires management to define its role. If the team is to function in a non-hierarchical, re-

engineered environment, its role must become much more customer-focused and holistic in recommending service improvements.

An Australian example where teaming was used effectively can be seen in the “enterprise-wide review” conducted by Mobil Oil Australia Ltd (Martin & Cheung, 2002, p. 447). The aim of the review was to increase profitability and change the culture of the organization. The challenge was to structure a leaner, more customer focused and flexible organization “to meet the competitive challenges in the global economy” (p. 447). Project teams were set up and team members nominated from different departments and locations in Australia and at different levels in the company, on the basis that they were able to contribute knowledge and ideas, were involved in some way in the issue, and had a stake in the outcome. The team members were junior enough to know the detail of the business but senior enough to understand the big picture. Each team was assigned a consultant as a full time facilitator and one or two executive champions, that is, senior executives, to provide guidance. Besides ensuring “an immediate financial success” (p. 456), the natural work team process “lifted awareness in the whole organization of the need to improve and change” (Martin & Cheung, 2002, p. 459).

Organizational leaders need to gain the trust and commitment of the group or work team in stressful management situations. In a recent study, Pillai and Williams (2003) focused on the processes that might explain how transformational leadership affects outcomes. They proposed that perceptions of follower self-efficacy and work group cohesion play an important role in the relationship between transformational leadership and outcomes such as commitment and performance.

They argued that when appointed leaders are trained to engage in transformational leadership interventions, they will motivate their subordinates to higher levels of service and commitment. These researchers adopted the view espoused by Podsakoff, MacKenzie & Bommer (1986, cited in Pillai & Williams, 2003), that transformational leaders influence followers to higher levels of commitment and performance by articulating a vision, fostering the acceptance of group goals and developing individual group members to reach their highest potential. House and Shamir (1993, cited in Pillai and Williams, 2003), suggested that the “primary motivational mechanism” through which these outstanding leaders influence their followers is by enhancing followers’ self-efficacy and self-worth (p. 146). Overall, Pillai and Williams’ (2003) results provided support for their model. Transformational leadership was related to perceptions of unit performance and commitment through self-efficacy and cohesiveness.

This sort of inspirational leadership could be seen in the example provided by the CEO of the Beta Hospital in the period preceding its transfer from the Commonwealth in to the State system. “The chief executive was particularly important in this. What really counted was his honesty and sincerity. Moreover, he engendered in people a lot of pride about the work they had done with veterans and were still doing. He gave them a lot of assurance that the history of that service would not be lost. Basically, he gave people hope for the future” (the Interviews).

While recognizing that “there are no easy answers”, (Pfeffer,1998, p. 1) posed the question of what high-performance management practices might be implemented to accrue benefit for people.

He suggested three guiding principles for transforming organizations to a high commitment model of management: “build trust, encourage change, and use appropriate measures of performance” (P. 2). Gee and Burke (2001) noted that the motivation of staff through financial incentives has only limited success because the motivation is only temporary. However, job enlargement, job enrichment, and job rotation are three key ways to adapt the employee’s task in order to maintain high levels of motivation, thereby allowing for the realization of employees’ higher needs for recognition and self-fulfillment (Gee & Burke, 2001).

Haudon and MacLean (2001) took the focus of change management away from the creation of a “great change management plan”(p. 255), and towards the engagement of people in the business “so that they can think differently and act differently about it” (p. 255). Change is a journey, and engagement is the destination. This requires sustained connection and undivided concentration. Haudon and MacLean (2001) are disheartened by the realization that in today’s businesses, people are not just disconnecting - they are actively disengaging or becoming disinterested. In this research there were comments such as, “people have left. Morale is so low because of continuing uncertainty about the future - people are continuing to leave because they have had enough uncertainty. You can have someone who was very functional in the old environment, that is, they had a place and a role and they were useful. They have become dysfunctional. People have lost their meaning” (the Interviews).

Sullivan, Sullivan and Bufton (2001) saw organizational change as best driven by an alignment of individual and organizational values.

Clarifying individuals' and companies' values can help to create a win-win outcome for all concerned, as "individuals can find meaning in their work and companies can develop a committed workforce that is able to function well through periods of change" (p. 247). In practice however, this would appear to be a hard "ask", especially in the situation where there has been an acquisition, or a merger where there is more than one set of alignments between the merging organizations and the workers. Given our understanding of the cultural divide which already exists between merging organizations, it would be extremely optimistic to assume that any alignment of merged individuals' and companies' values can be accomplished, at least not before a period of protracted conflict. In this research, for example, we can see this in perceptions about the "others" following the merger. "Post amalgamation, people who were at [one] former campus are seen as suspicious when you try to negotiate with them. They are ungenerous and resentful. Everything is too difficult for them" (the Interviews).

Ford (2001) relied on expectations construed from remembering past experiences, and visions derived from imagining the future, to determine organizational creativity and change. Weick (1995, cited in Ford, 2001) stipulated that meanings and significance attributed to past experiences, current perceptions, and future visions are created through sensemaking processes. Individual and collective sensemaking processes can influence the meaning given to historical events, the relevance ascribed to contingencies faced in the present, and the possibilities envisioned for the future. Decision makers who only understand the present in terms of past risk, are frequently caught off guard.

Organizational actors must address the degree of “futuraity” they need to factor into their present thinking and action, the time spans that need to be addressed, and how future considerations converge with prior knowledge and current concerns (Ford, 2001).

A diversity of change management theories and models have been reviewed in the preceding pages. All of these can be viewed as theoretical understandings contributing to a body of resources available to offer assistance when organizations are subject to change and restructuring, such as that which occurs as an outcome of acquisitions, mergers and amalgamations. As mentioned at the start of this chapter, amalgamations and mergers are comprised of a complex set of organizational processes and changes. They are also comprised of a complex set of individual and group responses. One such response by individuals and groups has been identified in the literature as survivor sickness. Survivor sickness has been identified as a debilitating process which affects those people who stay on in the restructured organization. In the present research we are focusing on the behaviours and feelings of a small group of people following the amalgamation of two hospitals. Amongst their many symptoms these people show stress, anger, decreased motivation and depression. Survivor syndrome has been identified as the significant feature affecting the participants in this research. It is time to turn our attention to survivor syndrome with a view to better understanding its origins and its natural history. Although this material could legitimately have been included as a part of this chapter, it was decided to treat it in a chapter on its own to emphasize the importance, to organizations, of treating merger survivors with the same respect, diligence, and care as they treat those who are retrenched from the organization.

CHAPTER THREE

SURVIVOR SYNDROME

The Human Cost of Organizational Change

This chapter attempts to give the reader an understanding of the origins and history of the research and literature on the concept of survivor syndrome. Attention is paid to the work of Valent (2001) as it is also concerned with hospital closures. Ciancio (2000) and Young and Brown (1998) are mentioned for their work in hospitals also. A number of other researchers discussed examined organizations in general, the reasons for mergers and downsizings and the effects on staff of the changes this caused. Noer (1993) is introduced and his Intervention Model examined. An indication is given of the work being done by researchers post-Noer, and the chapter concludes with a comment indicating the serious consequences of forced changes for the survivors of these changes.

As noted in previous sections, in Australia the early recessionary years of the 1990s brought with it an era of public sector downsizing - where, in an effort to minimize the budget deficit, cost cutting measures were put in place by both the Federal and State governments. This involved cutting back on funds allocated to many government agencies and departments which translated into extensive job losses in the public sector.

Dawkins, Littler, Valenzuela and Jenssen (1999) saw the downsizing trend in Australia following what occurred in the major OECD economies, where job destruction rates

appeared to rise to unprecedented levels, and where now “downsizing, or workforce reduction, is a dominant feature of firm behaviour in Australia in the 1990s” (p. 1).

Without doubt, the most negative feature associated with mergers and acquisitions, with their resultant restructurings, was that of downsizings or divestitures. In 1982, an American Management Association study found that of one hundred acquisitions, “over one-half led to major internal reorganizations and over one-third led to significant downsizing and reductions in force” (Mirvis & Marks, 1992, p. 41). Downsizing is a phenomenon that emerged from the necessities of the 1980s. In the 1980s and the 1990s and beyond, a wave of reorganizations, mergers, downsizing and other changes within organizations have transformed not only the nature of exchanges, but human resource management as well. Davis (2003) pointed out, that because human resources account for approximately 41 percent of expenses in service industries, in the health industry, in this industry “decreasing personnel costs through downsizing offers substantial savings” (p. 184).

If the anticipated advantages of these changes are promising and seductive, downsizing also has human costs that may annihilate the efforts undertaken. In this context, the human factor has become one of the principal determinants of success or failure. According to Pfeffer (1998) “it appears that the old aphorism, ‘people are our most important asset,’ is *actually* true [and] compelling evidence suggests that organizational success comes more from managing people effectively than from becoming lean and mean through downsizing” (p. 1). But while many organizational leaders believed that putting people first makes strategic sense, all too few did it.

Moreover, where the health industry was concerned, Davis (2003) found that “empirical studies about this topic are relatively sparse” while she cautioned that “the lack of empirical support for the effectiveness and success of restructuring efforts may have serious consequences” (Davis, 2003, p. 184). Davis (2003) reviewed the research literature, including aspects of general downsizing (for example, Kilpatrick, 1988; Taylor & Kleiner, 1998), survivor issues (for example, Brockner, Davy & Carter, 1985; Brockner, Grover, Reed, Dewitt & O’Malley, 1987; Havlovic, Bouthillette & Van der Wal, 1998; Kivimaki, Vahtera, Pentti & Ferrie, 2000; Valent, 2001), and healthcare, patient and quality of care issues (for example, Robertson & Dowd, 1996; Robertson & Hassan, 1999).

In view of the current research, a hospital study by Valent (2001), conducted locally, deserves immediate attention. Looking back to the 1990s, Valent discerned that many hospitals worldwide had been closed, at least in part on the basis of economic rationalism. As well, to a lesser extent, wards were closed or relocated all the time. Nevertheless, very little has been written about the human costs of hospital closures in regard to either patients or staff. Valent’s enquiries identified “only one study (Craig, 1997) [which] referred to staff responses and [which] cautioned against underestimation of the varied griefs of staff and patients following closure of a psychiatric hospital” (Valent, 2001, p. 150). To Valent’s knowledge, “no prior study has addressed the effects on staff of closure of a major general hospital” (p. 150). Valent’s study addressed this gap, and examined the planned contraction in its services and the ultimate closure of a major Melbourne metropolitan teaching hospital in 1991. The official explanation for the hospital closure was that amalgamation with another hospital would service a needy geographical area.

The similarity of circumstances between Valent's study and features of the current research (for example, geographical relocation and an amalgamation) is strong indeed.

Valent (2001) conducted semi-structured interviews with fifty, relocated senior medical staff and administrators. Nobody refused to be interviewed. In fact, staff were generally keen to talk, and many were grateful for the opportunity "to gain words and labels which enabled them to think cogently about what had been bothering them for a long time" (p. 151). Most subjects expressed "surprisingly intense distress" (p. 151). Themes could be categorized in terms such as "pained confusion at the meaninglessness of their world collapsing and their values being eroded" (p. 151). Staff felt "a kind of despair, alienation and apathy" (p. 153). Demoralization manifested in decreased punctuality and increased sick leave days, unofficial leave and resignations. Symptoms of burnout such as poor sleep, fatigue, lack of concentration, decreased functioning and irritability were common. In the current research, similar responses could be seen in comments such as "now they [the staff] are showing increased stress and volcanic eruptions, for example, How can I do this?, this place doesn't love me. There is more absenteeism, sickness, people looking unhappy, people being less tolerant, people saying I don't care anymore, stuff this place" (the Interviews). In the Valent (2001) study, stress responses such as anxiety were also mentioned, as were specific stressors such as unemployment. Overt symptoms and illnesses were often mentioned, but only as a seeming afterthought. A more recent Finnish study by Vahtera, Kivimaki, Pentti, Linna, Virtanen, Virtanen and Ferrie (2004) has indicated an increased rate of medically certified sickness, absence, and increased risk of death, after major downsizing among people who remain in work.

Cardiovascular mortality was twice as high after major downsizing as after no downsizing. No evidence for associations between downsizing and mortality from other causes was found. Nevertheless, these researchers believed that the associations observed in their study between downsizing, sickness, absence and cardiovascular mortality, “may represent an underestimate rather than an overestimate of the actual effect of downsizing” (Vahtera, Kivimaki, Pentti, Linna, Virtanen, Virtanen & Ferrie, 2004, p. 557).

In Valent’s (2001) study, as in the present research, political decisions about the hospital were based on ideologies of cost-saving, rationalizing, amalgamating and regionalizing. The staff rejected such views. In the Valent study the official rationale for the hospital closure was that amalgamation with another hospital would service a needy geographical area. When trying to make sense of the closure of a hospital that had been unable to cater even for local needs due to a chronic shortage of beds and growing waiting lists, staff in the Valent study theorized that the hospital must have been a victim of political animosities and misguided ideologies, including a general antimicrobial feeling of the times. For example, amalgamation was seen by staff as a euphemism for cutting service, while basic needs meant cheapness. We find similar official explanations offered, and sometimes cynicism as a response in the current research, where interviewees were told that the amalgamation was part of “the regionalization of hospital care, that is, moving hospitals to where people need them”. However, there was a perception here also that the amalgamation was determined politically and that the Health Department was meeting its own agenda for control of the hospitals through the process of the amalgamation. “There was very direct action by the Health Department (killing two birds with one stone).

It was probably more the Health Department which was the chief instigator. It was a bigger merger than one of the Alpha and the Beta. It was a merger between the Health Department and the Alpha and the Beta” (the Interviews).

Valent (2001) acknowledged a current school of opinion that closures and mergers, disrupted ways of working, and changes in values, are part of normal life these days, and that the distress accompanying them do not warrant special attention. He disagreed on three grounds. Firstly, they warrant attention because of the very reason that they are common, and therefore an understanding and amelioration of widespread stress effects may be beneficial for a wide section of the community. Secondly, normal distress, such as anger, outrage, losses, demoralization and a sense of corroded bonds and values, may cause at least as much suffering and anguish as illness. Thirdly, stress responses and demoralization are in the buffer zone between distress and formal symptoms and illnesses (Valent, 1998, cited in Valent, 2001), hence treating them “not only saves much suffering but is also good preventive medicine” (Valent, 2001, p. 153).

Valent’s (2001) findings can be extended to other situations where there has been an organizational restructuring involving a contraction of services. In general, it would appear that downsizing may be extremely traumatic for those remaining in any organization. “Regardless of organizational intention behind downsizing, the process of change and the employment outcomes can have a dramatic impact on employees’ working and personal lives” (Roan, Lafferty & Loudoun, 2002, p.1). Loss of colleagues is linked to anxieties about personal job security.

These employee reactions, coupled with the frequent reality that the same amount of work must now be accomplished by fewer people, makes work life difficult and stressful in the post-downsizing firm or organization. “This complex of damaged morale and crisis mentality has been labelled ‘survivor guilt’, ‘survivor syndrome’, ‘survivor sickness’” (Dawkins, Littler, Valenzuela & Jensen, 1999, p. 55). In general, survivor syndrome means the negative effects the remaining work force experiences after major organizational change. “These effects on the workforce can include anxiety, guilt, apathy, disengagement, and other mental and emotional states that result in workplace injuries (Dawkins, et al., 1999, p. 55). Gandolfi and Neck (2003) referred to empirical evidence which shows that the planning and conduct of downsizing of the work force is not confined to economic and organizational implications, but has significant human consequences. “Various signs of trauma have emerged among the remaining workforce, the survivors” (p. 198).

Ciancio (2000) tells the story about Lauren, the nurse, whose peers are gone; two trusted professionals and friends whose advice she could rely on. Now “she sees their abandoned coffee cups in the break room. Lauren hasn’t had time to use hers in two days” (p. 43). He asked rhetorically “but she’s lucky, right? She has her job” (Ciancio, 2000, p. 43), and the organization needs experienced nurses like her right now with resources so stretched. “So why can’t she move on?”. Why is it that “Lauren feels angry, alone, and distrustful of management. Will she be next [to go]” (p. 43). Ciancio used the story of Lauren to illustrate the pervasive dysfunctional emotions in the survivors caused by organizational restructuring. These emotions build up when survivors must suppress them to continue employment. We have clear indications of this build up of dysfunctionality in the current research. “People are feeling pressured because there are fewer staff to meet the same

commitments. People are frustrated by a feeling that professional integrity is being compromised. People are uncertain how it will all end up. People are resentful due to concern over equitable division of the workload. They are anxious about the future. Now there is a them and us attitude between the medical staff and the administration” (the Interviews).

Young and Brown (1998) detailed the significant downsizing of nursing staff in US hospitals from the early 1990s. For example, they cited Zimmermann (1994) who predicted an estimated loss of 750,000 new jobs between 1995 and 1997 as a result of the financial impact of health care reform. In the summer of 1993, the American Nurses Association reported the results of a survey of nursing layoffs. “Of those states responding, sixty percent reported layoffs or a threat of layoffs” (Young & Brown, 1998, p. 258). Ciancio (2000) reported that the sanitized terms we frequently use to describe these layoffs - restructuring, downsizing, or rightsizing - contrasts sharply with more violent descriptions. Jobs are targeted, eliminated, terminated by “cut-and-slash” tactics. Survivors “dodge the bullet” (p. 44). Downsizing introduces unpredictability and loss of control for the survivors. Feelings of anger and mistrust fester. Survivors may experience reactions ranging from generalized stress, to demoralization and depression, to burnout (Ciancio, 2000).

Davis (2003) found that downsizing had occurred in almost all US industries. On the one hand, approximately 80 million new jobs had been created since 1982; on the other hand almost 40 million jobs had been eliminated. For example, by the end of 2001, *Fortune* 500 companies reported cumulative layoffs of 1,040,466 positions. By April, 2002, more

layoffs were reported, adding 255,260 lost jobs to the already staggering numbers (Davis, 2003). Ryan and Macky (1998) suggested that while downsizing may remain primarily a reactive strategy to organizational bankruptcy or recession, downsizing had also become a proactive human resource strategy for other organizational situations, including the abandonment of divisional organizational structures, or as a result of mergers and acquisitions. All lead to the shedding of duplicated staff.

Ciancio (2000) commented that survivor syndrome starts with “the destruction of a psychological contract” (p. 44). This contract includes assumptions that the employee makes, based on his or her employer’s recruitment and subsequent behaviours. Assumed is that the employee can expect conditions such as trust, job security, opportunities for promotion, loyalty, fair treatment, respect and appreciation for good work undertaken. This contract gives workers psychological control over their work environment, which lets them freely invest themselves in performing their role.

There is a body of research activity supporting the assumption of a psychological contract (Ciancio, 2000). Rousseau and her colleagues (Rousseau & Anton, 1988; Rousseau & Aquino, 1993) raised the issue of the violation of implied contracts of employment in the termination practices of American corporations. “Contracts based on relationships are promise-centered agreements involving concepts, such as good faith, best efforts, vountariness, and fairness, where terms of the agreement include both overt promises (for example, of service or pay) as well as numerous variables parties take for granted (for example, loyalty, security)” (Rousseau & Anton, 1988, p. 276). Rousseau argued that implied contracts arise from observable patterns of interaction between parties in a

relationship. Beliefs held by parties to a relationship may be termed a “psychological contract”. A belief that arises out of this contract is that the organization has an obligation to try and retain an employee. Whilst involuntary terminations play an evergrowing role in employee turnover, how these occur “can impact the attitudes, well-being, and litigiousness of victims as well as the performance of fellow employees” (Rousseau & Aquino, 1993, p. 136).

In general, the concept of a psychological contract proves a useful framework for understanding the employee-employer relationship because “it focuses on the broader and often implicit issues of that relationship. When employees perceive that they have kept their ‘end of the bargain’ but that employers’ have not fulfilled their part, breach of the psychological contract is said to have occurred” (Littler & Maguire, 2001, p. 29). This violation of the psychological contract is also illustrated by Noer (1993) with the story of the managers Juanita and Charles who, “although they had traversed very different paths to their management jobs, experienced similar feelings of personal violation when the implicit psychological contract between each of them and their organization went up in smoke. It wasn’t long before they were both experiencing survivor symptoms of fear, anxiety, and mistrust” Noer, 1993, p. 4).

From the late 1980s, the downsizing of the workforce had become an ubiquitous feature of many organizations in the USA, and elsewhere in the developed world (Appelbaum, 1991; Cappelli, 1992; Gandolfi & Neck, 2003; Kilpatrick, Johnson & Jones, 1991; Ryan & Macky, 1998; Stoner & Hartman, 1997; Webber & Campbell, 1996). Simultaneously, there was support in the organization literature for the view that letting go of employees did

not result in longer-term improvements (for example, Dunphy & Griffiths, 1998; Ryan & Macky, 1998; Stoner & Hartman, 1997; Yallop, 1995). A strong view in the Australian context at least was that “it provides no automatic benefits and is often counter-productive” (Dunphy & Griffiths, 1998, p. 146). Stoner and Hartman (1997) described the practice of corporate restructuring resorted to by organizations over the past ten years as “surgery”, to ensure the corporation’s “long-run competitive survival” (p. 25). In many industries (Australian industries included), it appeared, downsizing continued to be regarded as the major strategy for lowering costs and increasing profitability, by eliminating unneeded layers of middle management, ridding the company of duplication and overlaps, and streamlining decision-making (Littler, Bramble & McDonald, 1994; Littler, Dunford, Bramble & Hede, 1997; Dawkins, Littler, Valenzuela & Jensen, 1999; Dawkins & Littler, 2001). But Dunphy and Griffiths (1998) acknowledged that “downsizing undertaken without a sense of strategic insight, as a blind reaction to the necessity to cut costs to survive, is more likely to be a formula for compounding the firm’s problems than solving them” (p. 147). Applebaum (1991) agreed. “Downsizing is not the miracle solution to reducing expenses in troubled times. It could well worsen the situation” (p. 12).

What needs to be given primary consideration is the downturn of staff morale and other negative results following severe organizational upheavals which result in the shedding of staff. What is the condition of those staff who remain in the organization? Whatever the original motivation for downsizing, as already suggested earlier in the chapter, there are also hidden costs associated with such layoffs, and “the advantages accruing to employers from downsizing have frequently been offset by the costs associated with re-hiring, survivor syndrome, reduced labour productivity and decreased employee commitment

(Littler, Bramble & McDonald, 1994, p. 9). For many, downsizings are viewed as “among the most dreaded events in organizational life” (Mirvis & Marks, 1992, p. 208). For decision makers, there is the agony of having to “play God” (p. 208). For managers taxed with breaking the news to employees, including long-time loyal subordinates, there is upset, doubt, and identification with displaced employees. For employees parting from the company as well as for those remaining, there are confusion and depression, a sense of victimization and fatalism (Mirvis & Marks, 1992).

Little interest was shown in the surviving work force before the mid 1980s and the work of researchers such as Brockner, Davy & Carter (1985); Brockner, Greenberg, Brockner, Bortz, Davy & Carter (1986); Brockner, Grover, Reed, DeWitt & O’Malley (1987); Cameron, Kim & Whetten (1987); Cameron, Freeman & Mishra (1991); Brockner (1992); Cappelli (1992); Brockner, Tyler & Cooper-Schneider (1992); Noer (1993); Webber & Campbell (1996). Brockner and his colleagues argued that layoffs engendered a variety of psychological states in the survivors of the layoffs - guilt and positive inequity, anger, relief and job insecurity - and that these psychological states had the potential to affect survivors’ work behaviours and attitudes, including level of performance, motivation, job satisfaction and commitment. These researchers looked carefully at many aspects of the “survivor syndrome” phenomenon, for example, that the dismissal of co-workers might engender perceived job insecurity (that is, anxiety) in the survivors. Consequently, the survivors might be working harder in order to avoid meeting a similar fate. In addition, anecdotal evidence suggested that survivors experience considerable remorse, or more extremely, “survivor guilt” when they are working, while their fellow employees have been laid off. It is not intuitively obvious that survivors should feel guilty about their co-workers’ dismissal.

It could be plausibly argued that survivors should not feel guilty, in that they are, typically, not responsible for making the decision to dismiss their peers. Why might they feel guilty? Brockner, Davy & Carter (1985) speculated that “according to equity theory, workers are very concerned with being treated fairly. That is, their ratio of work outcomes to work inputs should be commensurate with those of relevant others. Deviations from perceived equity (in either direction), according to the theory, will produce behaviour and/or belief change designed to restore perceived fairness” (Brockner, Davy & Carter, 1985, p. 230).

Brockner, Davy and Carter (1985) suggested that it might well be that co-workers’ layoffs can induce a state of positive inequity in the survivors. Survivors might feel that they, rather than their co-workers, could just as easily have been dismissed. Thus, while the worker’s survival of the layoff, while hedonically desirable, may also seem “unfair” (p. 231). Brockner, Davy and Carter (1985) explored the notion that layoffs caused survivors to experience positive inequity, which in turn can have motivational consequences. In order to reduce the sense of remorse or guilt over their co-workers’ dismissal, workers tend to increase their level of output. In a controlled study conducted by these researchers, some subjects witnessed the layoff of another worker. In summary, the findings were that the quantity (but not the quality) of the surviving workers’ task performance was enhanced by the dismissal of their fellow subject. Co-worker layoffs can have a dramatic effect on the subsequent productivity of the “survivors”. The design of this particular study suggested that it was the whimsical or arbitrary layoff that appeared to elicit strong feelings of positive inequity, and this spurred the survivors on to increased productivity (Brockner, Davy & Carter, 1985).

Brockner, Grover, Reed, DeWitt and O'Malley (1987) felt that more was needed: "a conceptual framework that can predict and explain the effects of layoffs on survivors" (p. 526) As we shall see a little later, Noer (1993) aimed to achieve this. "Anecdotal evidence has suggested that layoffs may decrease, increase, or have no effect on survivors' work performance" (Brockner, et al.,1987, p. 526). These researchers found the existing large body of literature on interpersonal and organizational justice especially relevant in this instance. Justice issues were perceived as salient for survivors at numerous points in the layoff process, for example, in questions about whether the layoffs were legitimate in the first place, or about the way the layoff decisions were made and how people were informed.

Moreover, aspects of the survivor situation resembled work already being done on the way individuals react to victims of injustice, for example, Adams, 1965; Deutsch, 1975 and Lerner & Lerner, 1981 (all cited in Brockner, et al., 1987). All the above work suggested that people may exhibit a wide variety of behavioural and psychological reactions including acknowledging or denying injustice, blaming the perpetrator or blaming the victim, and so forth (Brockner, Grover, Reed, DeWitt & O'Malley, 1987).

Brockner et al. (1987) suggested several categories of variables that would have a significant impact on survivors' reactions to layoffs. One is the extent to which the organization is viewed as having been unfair to the dismissed workers in the layoff process. Another related to survivors' prior identification with the layoff victims. It was expected that survivors would react most negatively (that is, their work performance and organizational commitment would be lowest) when they perceived that the layoff victims were treated unfairly *and* when survivors had a relatively strong sense of identification

prior to the layoff, with those laid off. In the present case, “the amalgamation led to insecurity among senior medical people. She [the Director of Allied Health] was told blatantly that her contract was not to be renewed. No one is left of the Alpha senior executive. I feel quite strongly that people were badly treated by the Network Board” (the Interviews). In another department (Dietetics), the interviewee became the new Head of Department following the post-amalgamation “wash-up” of positions. Her former counterpart had left and gone to another hospital as a result. “She [the former Head of Department] resented what happened. Status was a big issue for her [the former Head of Department]’. Afterwards, people would close their doors or stop talking and leave the room when I came in. They wouldn’t eat lunch or drink coffee with me. There was real antagonism - the atmosphere was thick with anger. Eventually they all left except for one person who was then OK” (the Interviews).

In relation to the role of perceived fairness, survivors’ perceptions of the fairness of the layoff are determined by their beliefs about *why* the layoff occurred, as well as *how* the layoff was implemented. Questions about *why* include, *Is the layoff justified?* Survivors need to believe that the layoff is truly necessary, rather than caused by managerial greed or incompetence. Questions about *how* the layoff was implemented might include, *In implementing the layoff, how well did the organization attend to the details?* Survivors’ reactions do depend to a significant extent on the apparently trivial details of implementation. Brockner, Grover, Reed, DeWitt and O’Malley (1987) and Brockner (1992), made the point that people needed to be treated with dignity and respect, especially during a painful procedure such as a downsizing. The organization that takes good care with the details of implementation is communicating (to both layoff victims and survivors)

that it respects the personhood of its employees; as a result, the layoff will be perceived as more fair. Fairness includes not only the outcomes (distributive justice) of the downsizing but perhaps, more importantly, the process (procedural justice). Both victims and survivors in a downsizing will evaluate the fairness of the layoff procedure (Ryan & Macky, 1998).

There is more than one model of downsizing that can be employed (for example, Cameron, Freeman & Mishra, 1991; Ryan & Macky, 1998; Gandolfi & Neck, 2003). Three types of implementation strategy have been identified that might be generally employed: the workforce reduction strategy; the organization redesign strategy; and the systematic strategy. These differing models describe how managers are influenced in their choice to reactively or proactively downsize; how the targets for downsizing are chosen, and the practices that are employed.

Workforce reduction strategies These refer to actions that eliminate individual jobs, such as layoffs, attrition, or buyouts, and retirement incentives. In a four-year longitudinal study conducted by Cameron, Freeman and Mishra (1991) which reported on organizational downsizing and redesign in the US automobile industry, these strategies were by far the most commonly used by downsizing firms.

Organization redesign strategies These are, by and large, medium-term strategies. They are used by firms to eliminate or re-position subunits within the organization, or to eliminate work. Sometimes eliminations of a hierarchical level are accomplished without a redesign of the work, but generally some kind of work redesign accompanies these strategies. In the research, we have already discussed the intention to redesign work

practices on one campus of the medical centre to help with the pre-admission of patients by amalgamating two small wards. The strategy was unworkable in that situation because of the attitudes of the staff involved (the Interviews).

Systematic Strategies These are aimed at changing the mind-set or culture of the organization. Instead of a single action or program, they involve a change in the way employees interpret and approach their work. Minds as well as actions become the target of change. These strategies can not be implemented quickly but are part of a long-term change process. Downsizing is redefined as a continuous, never-ending set of opportunities. No size or savings level need be set as a target because whatever the level is, it can be improved. The main advantage of systematic strategies is in helping the firm avoid the need for more short-term workforce reductions in the future, when another economic downturn or crisis occurs. Systematic strategies will be examined a little later in this chapter, particularly one suggested by Noer (1993) who offered strategies to transcend the experience of downsizing.

The most successful firms in the Cameron, Freeman and Mishra (1991) study implemented all three types of strategies. That is, they implemented both short-term (workforce reduction) and long-term (redesign and systematic change) strategies as they downsized. They used both across-the-board, and targeted, downsizing. They focused on the immediate measurable changes that were required, as well as unmeasurable changes, in the way work was defined and approached. Unfortunately, an analysis of the firms in the study that were downsizing supported the conclusion that most organizations were inclined to downsize in inappropriate or ineffective ways. They engaged in downsizing activities that

fostered dysfunctional outcomes (for example, decreasing morale and commitment, increasing conflict and criticism) rather than improved performance. Cameron et al (1991) felt that these behaviours were partly an outcome of these firms trying to be consistent in their downsizing approach, while effective downsizing was found to involve contradiction. That is, effectiveness was typified by processes that are often thought to be opposite or incompatible, such as offering certain employees incentives to remain in their jobs while others are given incentives to retire early.

The research of Brockner, Grover, Reed, DeWitt and O'Malley (1987), extended also to the post-layoff work situation. These researchers suggested that in the post-layoff setting, if organizations showed commitment to their dismissed workers, by providing caretaking activities such as severance pay and outplacement counselling, the more committed to the organization survivors are apt to be, and this effect is especially pronounced when survivors identify with those who are laid off. These findings have managerial implications. Firstly, the organization's caretaking practices can mitigate the negative effects of layoffs on the work behaviours and attitudes of survivors. Secondly, theoretical analysis, such as that by Brockner, et al (1987), suggested that it is survivors' perceptions of how justly the laid-off workers were treated (procedural justice) that moderates the effects of layoffs on those who stay. If this is correct, then organizations must do an effective job of communicating to the survivors its compensation practices toward those who are laid off. Brockner et al (1987) suggested that future research should explore further issues arising from the categories of variables they had examined, including whether or not the organization provides ample warning of its layoff plans, whether or not survivors have ever been layoff victims themselves, and the extent of survivors' prior level of

identification with the organization (rather than with their former co-workers), amongst others.

In a later paper, Brockner (1992) noted that there was no simple or single answer to the question of the effects of layoffs on survivors. However, if the factors that influence survivors' reactions can be identified, then the advantage to managers is that they will be able to make more informed decisions about how to handle layoffs. On the plus side, Brockner felt that many of the determinants of survivor reactions are factors that managers can influence. If the layoffs are mismanaged however, thereby hampering survivors' productivity and morale, "then the organization stands to lose a sizeable portion of the savings it hoped to achieve by introducing layoffs" (Brockner, 1992, p. 10). For example, in the hospitals that are the focus of the research, post-amalgamation, "people are floundering, communication is poor, the overall feeling is that everything is out of control and there is no one there to influence it. The amalgamation has meant that most people suffered enormously - there is fear and anxiety. There are changes, such as having to work on two campuses instead of one and people find this a bit frightening. They have to get used to the way things are done there which is different to what they know. At a day-to-day level, people find it confrontational all the time. It was a period of profound uncertainty. The process of change could be characterized as a drawn-out clandestine approach which sapped morale" (the Interviews).

Survivors are influenced not only by the perceived fairness of the layoffs, but also by changes in their work setting which often accompany layoffs. The general finding emerging from research is that survivors' productivity and morale decline more if the

changes represent threats, rather opportunities. Specific concerns might include worry about the possibility of further layoffs, concerns about possible changes to the nature of work following a layoff, concerns about future prospects, and concerns about the reactions of fellow survivors. “Typically, downsizing results in a dramatically changed organization [where] survivors are likely to find that their job has been significantly modified or even eliminated” (Allen, Freeman, Russell, Reizenstein & Rentz, 2001, p. 145). Not only are survivors keenly attentive to objective changes in their work environment (that is, whether their workload has increased, or whether their career opportunities have diminished), but they are acutely aware of their fellow survivors’ reactions to the new work environment. For example, they monitor whether their fellow survivors seem more or less withdrawn from the organization. Their own reactions along those dimensions are determined to a significant extent by those fellow survivors, particularly those in their immediate work group. In the research it was noticed that post-amalgamation “people feel devalued in the organization. Morale is pretty low. People are resentful and feel unappreciated, therefore they are no longer prepared to go that extra mile. People in health care gave more than was expected because they wanted to. Now they are no longer happy to do this. People are angry and pissed off” (the Interviews).

The literature offers practical solutions to help managers avoid more negative outcomes, for example, by incorporating survivor transition support and outplacement support in the downsizing strategy (Kueffer & Powell, 1997); by ensuring that the downsizing which has occurred is part of a total strategic reorientation of the organization and a prelude to moving to a process of continuous adaptive change (Dunphy & Griffiths, 1998); by projecting a message to the survivors that the company really cares about its displaced employees via

services including counselling, seminars, job search workshops, placement services, and so forth, for those who have been laid off (Appelbaum, 1991); and by the appointment of a transition team to manage the restructuring process (Roan, Lafferty & Loudoun, 2002). Brockner (1992) suggested steps such as the provision of ample advance notice, the communication of full information to the surviving population, the treating of both victims and survivors with dignity and respect, and by helping survivors to recognize new opportunities, and so forth. Littler (1997, 2003) believed that a cluster of six human resource factors defined survivor syndrome, including job satisfaction or dissatisfaction; staff motivation; perceived promotion opportunities after the change in structure; staff commitment to the organization; morale, and concern about job security or job insecurity. However, “if you want to look at a key factor or a key variable that is driving a lot of survivor syndrome issues, negative survivor syndrome issues, then the key factor is job security” (Littler, 1997, p. 6). The prognosis in the literature is not always encouraging for a speedy resolution. Brockner (1992) warned that there was no quick fix. “Layoff managers should prepare themselves for an adjustment period measured more appropriately in terms of years than in months or weeks” (p. 27).

Organizational downsizing, as we have seen, does not necessarily generate the outcomes intended of it, and may, in fact, result in contrary and largely unanticipated consequences. In particular, it is doubtful if downsizing necessarily generates the productivity gains assumed to accrue from it. Evidence has already been accumulated in this chapter that organizational downsizing can result in poor morale, lower organizational commitment, reduced loyalty and trust, as well as lower productivity for those who remain with an organization after a downsizing. The evidence, both empirical and anecdotal, suggests that

management has been jumping on the “downsizing bandwagon” without properly preparing for the possibility of negative business consequences, as mentioned above. Ironically, “companies instituting programs to nurture employee commitment are often the same as those adopting downsizing and delayering as a way of life” (Ryan & Macky, 1998, p. 43).

In contrast, however, the researcher David Noer (1993) developed a people-centric, rather than an organization-centric perspective of the impact of a major organizational upheaval on individuals. Noer’s aim was to recognize the normal, but emotionally crippling symptoms of survivor sickness. Subsequently, he developed an intervention model to empower survivors and organizations and to restore energy, productivity and risk-taking in the downsized environment, which this thesis will examine in more detail shortly.

Noer’s (1993) model developed out of two studies he conducted in 1987 and 1992 in a US-based organization where layoffs had been instituted to assist with financial difficulties. The organization had a strong attachment to the old employment contract (that is, that employees could count on a job until they retired or chose to leave), and it provided support services that promoted employee dependency. The psychological bond supporting this relationship was seen to be violated when the organization instituted layoffs. In the intervening years between the two studies, the organization went through a series of major downsizings, and the layoffs continued unabated. The group in the second study had been employed under the old work contract, had survived the layoffs, and were now attempting to deal with the reality of the new employment contract (that is, that no employees can count on long-term employment). Having survived the layoffs, these people were clearly

fearful, angry and depressed. Yet this was “the same work force that was expected to turn the organization around and meet global competition” (Noer, 1993, p. xiv).

Similarly to the present case study, Noer (1993) adopted an interview format which encouraged people to reveal how they had been affected by organizational upheaval. Interviews in Noer’s initial study, and in the follow-up study, concentrated on survivor’s own accounts of their feelings and concerns, which Noer arranged thematically. It is the voices of the survivors themselves that we hear, and therefore we are better able to appreciate “the depth and seriousness of layoff survivor sickness “ (p. 54).

Noer’s research alerts us to the reality of the somewhat naively held notion that layoffs will reduce costs and promote an efficient, lean and mean organization. He observed rather, that what tends to result is a sad and angry organization, populated by depressed survivors. “The basic bind is that the process of reducing staff to achieve increased efficiency and productivity often creates conditions that lead to the opposite result - an organization that is risk averse and less productive” (Noer, 1993, p. 6). What Noer sees as the key variable in this situation is the survivors’ sense of personal violation. The greater the perception of violation, the greater is their susceptibility to survivor sickness. This perception of violation appears to be directly related to the degree of trust employees have had that the organization will take care of them. As so many organizations of the past have had strategies of taking care of their employees, this basic bind is the prevailing issue.

Noer (1993) viewed layoffs as an inevitable consequence of new and long-term economic and social forces: “no-fault, long-term change” (p. 28). “We are in the midst of a

fundamental paradigm shift” (p. 15). As such, organizations that used to perceive people as long-term assets to be nurtured and developed, now see people as short-term costs to be reduced. This represents a fundamental shift in the psychological covenant between the organization and the individual. The concept of treating people like other capital assets, conceptualizing them as an investment and amortizing their costs over time, is an excellent way to think in the new paradigm. “Managers did not make the paradigm shift happen, or set out to trade people for cost reduction” (p. 28). All levels of employees (including top executives, middle managers and first-level supervisors) “are in the same boat, part of the same uncomfortable, often painful, cultural voyage” (Noer, 1993, p. 29).

Noer referred to Robert Lifton’s (1967) analysis of Hiroshima atomic bomb survivors for a description that can be applied to all survivor situations. Lifton identified themes such as “death imprinting” and “psychic mutation” (p. 45). Death imprinting causes mourning for the way things were, for beliefs that have been shattered. Although there is an immense difference between the horror and fear faced by Hiroshima survivors, and the disruption and uncertainty faced by those who remain in organizations after reductions, layoff survivors are also imprinted by the layoffs. They mourn the way things were - the good old-paradigm days that have been destroyed.

“Psychic mutation” describes the altered perception of reality that individuals succumb to in order to get through terrible events. Layoff survivors are seen as flat, tired, and risk averse. Being “up” and positive often seems countercultural. However, hunkering in the trenches, not taking risks, and keeping a tight rein on emotions that need airing, are

defensive reactions that are neither healthy for the individual, nor productive for the organization. This defensiveness causes layoff survivors to perceive vitality as immoral.

As well, Hiroshima survivors suffered from survivor guilt directly attributable to the deaths caused by the atomic bombs. Deep, and often unexpressed or not understood, feelings of being abandoned, lead to this survivor guilt. In Hiroshima, as well as in the death camp survivors of the Holocaust, this was expressed as resentment towards those who died, and who therefore escaped the consequences of survivorship. The work of Brockner et al (1985; 1986) showed that a form of survivor guilt exists in layoff situations, even though normally no deaths in a literal sense are involved. Layoff survivors who feel depressed or saddened by, for example, empty offices or extra parking slots in the executive parking garage, are manifesting survivor guilt. In the current research it was noted that “a bunker mentality is what results from the present situation, and symbolically, the empty ward is still there. You have to walk through it to get to the other section. People who have worked in the unit remember the good times and are saddened by it. It has become a living symbol of change” (the Interviews).

Lifton (1967) described the survivors’ need to come to a gradual recognition of the new reality of the world, which no longer contained that which has been lost. Similarly, the cure for layoff-survivor sickness required that the survivors accept the new reality and let go of the old paradigm. A cure demands that survivors muster up the courage to break organizational codependency, and live organizational life as adventurers rather than as victims (Noer, 1993).

Noer's Four-Level Model of Intervention

According to Noer, concrete action is the only way to check survivor syndrome sickness. He proposed four successive levels of intervention, with the positive results of each level consolidating and reinforcing the impact of the next. "Layoff survivor sickness is complicated, and the cure does not lend itself to a one-dimensional prescription" (Noer, 1993, p. 83).

As noted earlier, Noer's perspective is people-centric rather than organization-centric. This is important because his model starts with the individual and then places that individual within the organizational context. From this perspective Noer looked at the impact of a major organizational upheaval on individuals, and how they might then be helped in the new order to participate via a changed work contract, in a new paradigm of work.

Level One: Need For Information. The first intervention level has to do with the downsizing process, from the vantage point of the survivors. The action taken at this level is not intended to cure the syndrome, but rather to keep the survivors from sinking any further. Level One interventions are tactically important, as they prevent survivors from sinking too deeply into the quagmire of depression and guilt. The key is to recognize survivors' need for information. Survivors are "information junkies" (Noer, 1993, p. 97). Layoff planners should communicate everything that is going on. This sort of intervention found expression in the current study where there were reports of a deliberate "cascading" of information by the Director of Clinical Services at the Beta Hospital as it was being transferred from the Commonwealth to the State, preceding its amalgamation with the

Alpha Hospital. “A team brief concept was developed and the dissemination of information was accomplished economically, via a core of individual representatives from across the hospital. These representatives were relatively senior but able to convey clear messages and then provide feedback. A management forum already existed which predated the hospital briefings. This was always well attended. It covered what the changes might mean for the organization. It called meetings and senior people were expected to attend. The group met on a fortnightly basis, at a regular time. People would talk to the Director on a limited number of topics (with sometimes recurring themes) and take close notes. Then these people would go out and report to the next level of supervisor and so forth till the lowest common denominator [was reached], within forty-eight hours. This included the night staff” (the Interviews).

There were other arrangements as well. “Staff open forums were held as frequently as needed - monthly, at the base level of frequency. They attracted anything from one hundred to six hundred people. They [the forums] were piggy-backed onto the hospital briefing. They dealt with a specific range of issues. The agenda was handed out, but staff could come along and ask about anything. Also, hospital transfer updates were initiated. A written bulletin was put out [usually fortnightly] that reiterated what people had been told at the forums. Finally, a regular afternoon tea was held, probably once a month. This was afternoon tea with the executive. People were encouraged to come and talk to the executive about anything they wanted to discuss” (the Interviews).

Level Two: Producing a Catharsis. The second level of Noer’s (1993) intervention model is aimed at producing a catharsis, that is, facilitating the expression of repressed feelings

and emotions for the survivors. Noer supports individual counselling and therapy although he feels that group work is the most effective and efficient method of bringing survivor emotions to the surface. He cautions that this kind of intervention should not be attempted without an initial diagnosis, a supportive boss, and a skilled facilitator who will help work teams to come to grips with all facets of their repressed feelings. In the current research there was a perception from the former Alpha Hospital interviewees that this area was woefully mismanaged. There was “a bit of counselling via the psychiatric services but not much. One counsellor position ... was only advertised two weeks [ago and was not yet filled by the time of the interview]. On a systemic scale, help for people is just starting. It is too little, too late, for example, change management workshops, vocational counselling, individual counselling. However, the medical staff won't go to change management workshops. They are a maverick lot” (the Interviews).

At the Beta Hospital, support was much more forthcoming. At the transition from the Commonwealth to the State stage, “people were offered counselling and a staff counsellor was provided. Group counselling was also offered. People got up to six sessions free with a counsellor, however, if someone patently needed more, it was given to them. The counsellors reported to someone in Human Services. There was still the availability of counselling post-amalgamation, but this was much less publicized. People were still using it, and they were not all ex-Beta people. Some of them were ex-Alpha Hospital people. It was a mixture of people” (the Interviews).

Level Three: Empowerment. Noer's (1993) third level of intervention is aimed at breaking individual's dependence on the organization, and enabling them to regain ownership of

their feelings of control and self-worth. His strategy for facilitating organizational codependency involves tapping into a core purpose. “Detachment and letting go involve removal; connecting with a core purpose involves a putting back” (p. 150-151). According to Noer, each person must determine his or her unique purpose in life. The origin of an individual’s purpose ought to start with the individual and spill out into organizations.

In comparison, Brockner (1992) emphasized organizational responsibility for dealing with survivor syndrome. He believed that the impact of downsizing on the survivors could be diminished by positively influencing the determining factors, namely the perception of fairness and changes in working conditions. He proposed three basic stages: before the layoff; during the layoff; and after the layoff. Before the layoff there is a need to assess the relationship between the downsizing and corporate strategy and culture. Individuals affected by the layoffs should be notified well in advance. Key people who will be involved in the new organization can be identified, and training provided for managers and supervisors. During the downsizing period it is important to provide full information to employees, overcommunicate, provide assistance and treat both victims and survivors with dignity and respect. Brockner suggested using ceremony, that is, organizing events such as meetings, to facilitate the transition. This strategy resonates with the information-giving tactics employed in the present research. In the “After” stage “the surviving workforce will need to regroup” (Brockner, 1992, p. 24). Brockner’s plan at this stage includes soliciting employee participation, providing job enrichment, and making sure that survivors recognize new opportunities. The organization’s responsibility “is to make explicit to survivors the opportunities present in the post-layoff environment” (p. 26).

Level Four: Creation of Organizational Systems and Structures. Noer's (1993) final level of intervention involves the creation of systems and organizational structures which reflect the new work contract, and which recognize a new paradigm culture, where, for example, employees should be encouraged to move in and out of organizations as their own, or the organization's needs require. Organizational leaders need to be "meaning makers" who "structure a confusing and ambiguous environment toward some unifying purpose" (Noer, 1993, p. 190). Moreover, leaders must be open to feedback and understand their impact on others. They must be clear about their own needs so that they do not work on their own agendas at the employees' or organization's expense.

This clearly was a formula which was not followed in the period following the hospital amalgamation. What transpired was "not about individuals but about winners and losers games. At first, it was all about who was going to get what job at the management level. You have fairly senior people cruising along who don't get the job and this is the first time in twenty years for many who are being told that they aren't up to scratch. In the majority of cases these people are leaving, however, a small number are still here and if they did not become reconciled they have remained very unhappy - openly destructive. Some people were ostriches. They dug their heads in the sand and didn't acknowledge that change was happening. People's own work is not attributed to them but to the new CEO, and some of the executives are taking credit for things they haven't done. The impression is that the Network is filling itself up with people who do not appear to have the interests of the Medical Centre at heart. A major problem for the staff is uncertainty due to a lack of consolidated direction. People perceive that the organization has lost its clear sense of

purpose. People are not part of the decisions. They don't own them in the same way" (the Interviews).

Perspectives on Survivor Syndrome Post-Noer

Noer opened the way for others to examine the problem from the perspective of the individual. Kaye (1998), for instance, made a distinction between three groups of people in organizations: POBBOs (those layoff victims who have been pushed out of organizations but who have ended up better off); SOBBOs (those survivors who provide an encouraging example of a bright future for themselves and their downsized organization by staying on and building options) and HOBBOs (those survivors who get stuck and are hanging on but are "bummed out").

It would appear that not all survivors are "debilitated members of the work-force" (Kaye, 1998, p. 35). Some people (SOBBOs) have learned valuable lessons about the reality of contemporary employee-employer relationships. They have moved past the debilitating backwash caused by waves of downsizing. They have productively retooled their ideas and plans about their current jobs and professional futures. They are valuable contributors who "actively seek a match between the contributions they make and the future they carve for themselves within or outside of their current organization" (Kaye, 1998, p. 35).

HOBBOs do not do so well. The members of this group experience the sadness, anger, mistrust, and psychological uncoupling from their organizations that most survivors experience. They are stuck in those emotions and they feel trapped in jobs that no longer

engage their full energy, interest, or talent. This group does not see a way out. They know that the axe could fall again. They mourn the loss of what used to be, and they feel mistreated and unrecognized. So do SOBBOs, but they “don’t get off on it “ (Kaye, 1998, p. 35).

While both SOBBOs and HOBBOs, in the short-term, experience some common reactions and share common concerns and complaints, for example, increased workload and limited staff resources, the key difference is related to their long-term coping responses. HOBBOs vacillate between denial about the long-term realities of an unsettled situation and a sense of powerlessness about influencing the future. SOBBOs manage to stay on but build options by being active regarding their current positions and future possibilities. SOBBOs network, learn, take on new assignments, and assess their capabilities. They also contribute to their organizations by approaching their current positions with motivation and energy (Kaye, 1998).

Kaye (1998) advised managers and leaders to capitalize fully on the talent remaining in the organization by addressing and motivating both SOBBOs and HOBBOs continually. People need to recognize which of these two groups they fall into and decide what to do about it. Nowadays, the employment pattern is more about a person, than a position or career path. People need to control their own career destinies by forging personal responses to a wide variety of possible organizational events such as contracting and downsizing.

Layoff survivors face a work-world turned upside down. The contract of loyalty and trust between employees and their employer has been breached and there is little likelihood that a new contract can ever be established. “That’s the breeding ground of HOBBOs” (p. 37). Kaye (1998) does not want us to give up on HOBBOs. She adopted a four-phase model to identify the stages that people experience when confronted by change: denial; resistance; exploration and commitment. HOBBOs get stuck in one of the first two stages, denial or resistance. Managers and Human Resources (HR) professionals have to recognize that HOBBO symptoms may result from HOBBOs incapacity to move on for the moment, and that it is not necessarily permanent or an issue of performance. Managers and HR professionals have to continue to invest in HOBBOs as they would in any other long-term capital asset. Kaye’s (1998) underlying notion was that employees and employers can begin the long road back after cutbacks to mutual trust and contribution, providing new strategies are employed for addressing the needs of the cutback survivors, whether they are HOBBOs or SOBBOs.

Allen, Freeman, Russell, Reizenstein and Rentz (2001) employed transitions theory as a guiding framework for their examination of changes in survivors’ attitudes following an organizational downsizing. The primary objective of their study was to examine changes in work attitudes over time. These authors felt that “the need for longitudinal data cannot be overstated” (p. 146), when investigating survivors’ reactions. They expressed a concern that researchers frequently failed to test whether or not post-event phenomena hold over time.

Allen, Freeman, Russell, Reizenstein and Rentz (2001) defined work role transitions as any major changes in role requirements or work context. Typically, downsizing results in a dramatically changed organization. Moreover, survivors are likely to find that their job has been significantly modified. A major source of job change results from organizational downsizing. Consequently, "it seems reasonable to consider survivors' reactions within the framework of work role transitions" (p. 147).

These researchers proposed that while survivors' initial reactions to a downsizing may be negative, it may be, after a settling-in period, that more positive experiences occur. Reminiscent of the SOBBOs in the Kaye (1998) study, some individuals may experience a downsizing as an opportunity to grow and develop in their job. Fewer layers of management may mean more autonomy and increased opportunities for those who remain in the organization. New or different career options may be opened due to the elimination of deadwood. In fact, healthy adult development may depend on periods of both change and discontinuity, as well as periods of stability and continuity (Allen et al 2001).

The study predicted a relationship between environmental and outcome variables. How individuals respond to a potentially stressful situation, such as a downsizing, is dependent on how they appraise or interpret the situation. If survivors do not trust that top management is competent and honest with employees through a downsizing, they are likely to withdraw from the organization, or otherwise respond destructively. Additionally, if work is not redesigned in a manner that will minimize overload, survivors are more likely to respond negatively (Allen et al, 2001).

Not surprisingly, the findings of Allen et al. (2001) indicated that the most negative impact on survivor attitudes occurred during the immediate post-downsizing period. After a longer period of time, attitudes generally reached more favourable levels. In summary, it is suggested that downsizing seems to have an effect on work attitudes, that this effect varies over time, and that the initial impact is generally negative. Moreover, the findings suggested that organizations may be able to keep downsizing survivors committed and less likely to leave the organization, by focusing on providing role clarity, reducing role overload, and increasing satisfaction with security and top management.

Studies focusing on nurses working in hospitals, (for example, Ciancio, 2000; Davis, 2003; Young & Brown, 1998), support these insights. The evidence suggests that nursing staff experience a range of emotional reactions as a result of a downsizing, including uncertainty and insecurity, frustration, fear, resentment, distrust, a feeling of unfairness, sadness, anger and depression (Young & Brown, 1998). Ciancio (2000), identified passive-aggressive patterns of behaviour, for example, griping, negative attitudes and sarcasm, extending to direct sabotage as revenge against their employers at the extreme. Amongst the many studies reviewed by Davis (2003), the findings of Wagar (2001, cited in Davis, 2003), who explored the outcomes of permanent workforce reductions, found an increase in the number of grievances filed, absenteeism, conflict, poorer supervisor-union employer relations and lower overall employee satisfaction. However, while the organization is counting on nurse employees to make the new reorganized vision a reality, employees are sometimes “unwilling, but more often unable” to contribute (Ciancio, 2000, p. 45).

Studies are generally realistic about accepting the practicality of downsizing and other forms of organizational restructuring such as attrition and relocations, as tactical strategies. But, as a parallel consideration, “strategies are necessary to protect remaining staff” (Davis, 2003, p. 194). Ciancio (2000) examined managers who are in denial about their own roles, and who fail to recognize the suffering around them. “They can’t admit error, even in the face of evidence that their plans aren’t working” (Ciancio, 2000, p. 45). Managers must start by admitting there is a problem and confronting the denial that exists in the hospital. Nurses and their leaders need to admit that survivor syndrome is real and that the organization is susceptible. Nurse leaders must enlighten their peers.

Ciancio (2000) counselled that managers should show compassion for staff. Managers should never discount the nurses’ feelings, or worse, push the ‘you should be grateful’ myth. By addressing the suffering, employees’ can accept the change as final, even if they find it unfair. Managers can help by encouraging the grieving process. As well, both sides need to work toward honest communication (a difficult task considering the employees’ mistrust and anger). Outside counselling can help. Ciancio (2000) contended that nurses will only be empowered to practice nursing when they begin recovery from survivor syndrome.

In another study, Young and Brown (1998) surveyed forty-eight vice-presidents of hospitals planning to decrease staff size. Of the thirty-one who returned questionnaires, eleven reported recent downsizings requiring the closing of one or more units. All eleven of the respondents indicated that attrition, that is, a reduction in staff size, was the most common method used to downsize, that is, to achieve a reduction in overall size. The next

most frequently used methods were relocations, early retirements, a change in skill mix and layoffs, that is, laying off workers. One vice president reported using enhanced severance pay as an incentive for staff to leave. All eleven vice presidents who experienced downsizing used attrition as a method for downsizing, and all except one used several other strategies.

All of the vice presidents who used downsizing as a strategy reported staff who were experiencing uncertainty and insecurity. Other responses to the downsizing included frustration, fear, resentment, distrust, a feeling of unfairness, sadness, anger, and depression: a familiar liturgy. As in Noer's (1993) data, guilt was "not identified as a major theme" (Noer, 1993, p. 67). Vice presidents reported observing guilt least often (Young & Brown, 1998).

The vice presidents involved in the downsizing were asked to provide information on the strategies and interventions they found most helpful during the experience. The vice presidents reported the importance of planning prior to downsizing. "Each step in the process needed to be calculated and precise" (Young & Brown, 1998, p. 261). Nurse managers were prepared to support and assist the staff during these trying times. Management visibility and access were essential. When attrition and relocation were used, allowing staff to make decisions concerning their new positions helped resolve feelings about the downsizing. In some instances, educating the staff on national trends and the increased costs of health care helped them accept the plans for the downsizing.

Evocative of the reports of interviewees in the current research, ongoing communication, for example, open forums, discussions, staff meetings and individual conferences, was identified by all vice presidents as a key strategy. During the downsizing process, vice presidents reported that communication was ongoing, with sometimes more intense meetings scheduled with the staff affected. Counselling was provided by one vice president to help the staff grieve. It was important for the staff to deal with “what was” and “what will be” (Young & Brown, 1998, p. 261).

The eleven vice presidents involved in downsizing identified most of the symptoms corresponding to the survivor syndrome described by Noer (1993). Rebuilding trust and assisting staff in forming new alliances were seen as beneficial strategies. Other suggestions included keeping the staff informed about changes in health care needs, working collaboratively with other departments to assure quality patient care, being open with staff, supporting managers who supported the administration, allowing staff to make decisions on relocations, and, when feasible, using outside consultants to ensure that labour relations were not compromised. Above all, the most important contribution of this study, however, is the report of “the importance of clear and continuous communication between administration and staff throughout the downsizing process” (Young & Brown, 1998, p. 262).

Davis (2003) agreed that “an implementation plan must be in place” (Davis, 2003, p. 194). She pointed out, furthermore, that when hospitals are involved in a downsizing, given the connection between staff and patient satisfaction, efforts to maintain staff satisfaction after layoffs should ensure that patient satisfaction does not suffer. This can be achieved via

informal support activities, such as information exchanges that benefit staff and protect patients from hearing rumours from staff, or by management-facilitated workshops to educate staff on the downsizing process.

Davis (2003) believed that addressing survivors' concerns and fears early is important. Survivors may feel guilty because they have jobs, and they may lose trust and confidence in management. This might lead to Ciancio's (2000) concern about people sabotaging the organization by decreasing productivity. Particularly damaging is if the quality of care suffers as a result of the actions of unmotivated surviving clinical staff. Reestablishing trust and loyalty and improving morale are vital. Management should have frequent meetings with surviving staff and include them in the rebuilding process. For staff reductions to be effective, "long term and structured planning must be in place" (Davis, 2003, p. 195).

SOME COMMENTS MADE

We have monitored the history and research which forms the background for the transition of Australian organizations from a discourse of public bureaucracy to one of economic rationalism from the late 1980s to the present. In Australia, as in Europe and the US, the pre-1980s was characterized by healthy post World War Two economies resulting in the growth of large organizations and public bureaucracies. In this organizational paradigm, it was assumed that bigger organizations meant better organizations, and that unchecked growth was a good thing. Employer-employee relationships implied a long-term commitment nourished by a culture of loyalty to the organization. In exchange, the organization removed many of the employees' financial risks by providing benefits such as insurance, disability and retirement plans.

From the end of the 1980s, several of these basic assumptions regarding organizational performance have been transformed. This has occurred simultaneously with the rise of the market economy, and organizational responses to events such as failing markets and the 1987 stock market crash. Economic rationalism has become the dominant global discourse. An important aspect of the market economy, or economic rationalist perspective, has been the perception that the elimination of jobs and livelihoods can somehow be regarded as an economic virtue. Smaller can mean better. Downsizing and slowed growth can be natural, desirable phases, of the life-cycle process. In this chapter, we have reviewed the efforts made by organizations, including hospitals, to "cut the slack" and improve efficiency and productivity by employing strategies resulting in workforce reduction. Unfortunately, this

has had serious, and often unforeseen, consequences for the workforce left behind: “the survivors”. In the current research, the survivors reactions to the events following the amalgamation of two hospitals incorporating a workforce reduction are elicited using a narrative methodology, which allows them, as in the Noer (1993) research, to express their lived experiences. In the next chapter the history and theory of narrative will be explored, as a prelude to the survivors stories.

CHAPTER FOUR

NARRATIVE AS THEORY

The Choice of Narrative

Narrative was the method chosen as the research tool for the current research, where the concern has been to observe and closely examine the complexities and patterns emerging from the employment experiences of a small group of workers attempting to deal with the consequences of a hospital amalgamation. In other words, the research is interpretive, using narrative theory to underpin the narrative method used to collect data and analyze it. That the research represents a single case-study (a case-study often being seen as positivist or post-positivist in nature) does not, this researcher argues, obviate the narrative method of data collection and interpretation. In this instance, the single case-study is a structural device used to encapsulate the narrative; that is, to set a boundary around it. It is assumed that by allowing each individual to tell the story of their own unique experience, a rich output of material can be collected. It should be noted, moreover, that the words narrative and story will be used interchangeably in this thesis. A lengthier discussion on this point is to be found towards the end of this chapter. Once the material is processed and analyzed, patterns of similarity or difference can be ascertained and this can assist with a broader understanding of the issues involved.

Narrative research method is often the research tool chosen for accessing behavioural issues. It is able to raise the hidden to view (Davies, 1992). In writing about her own research into management development and training, Davies examined her growing concern “to find more intuitive ways of dealing with the complexity and ambiguity of life” (p.211) than that provided in the past by more objective and analytical literature on management, or by that which was descriptive of what managers do. It is only through allowing individuals the freedom to explain their own career paths, she said, that people can begin to discover the meaning of what sometimes had seemed random or lucky choices. “This narrative illuminated for them patterns which had at first seemed random” (p. 208).

“Telling stories about past events seems to be a universal human activity” (Reissman, 1993, p. 3). Each of us has a story to tell and a path which seems unique, and yet has many points of contact with others and with the times in which we live. But, as Davies (1992) stipulated, it is essential to view narrative as more than just a device for generalizing from individual career biographies. Narrative provides a way to bring patterns and issues to the surface where they can be understood at a level other than the rational external systems with which we too often order our lives. It [narrative] has a contribution to make in comparison with other research processes which tend to be written in “an esoteric language and structure designed for inside networks and citations” (Davis, 1992, p. 212). For example, organizational narratives are used to help newcomers and outsiders understand the reality of organizational life. Davies cautioned, however, that as a type of learning, narration is often less comfortable and attractive than the sanitized solutions of objective, rational systems.

As a potential research tool narrative has a remarkable provenance. Richardson (1995) reminded us that narrative was everywhere. We rely on our lived experiences. Children everywhere learn to listen and tell stories at a very early age. The narrative is present at all times, in all places, in all societies. Richardson (1995, p. 200) referred to Barthes (1996) who remarked that “the history of narrative begins with the history of mankind; there does not exist, and never has existed, a people without narratives.” According to Jerome Bruner (1986) narrative reasoning was one of two basic and universal human cognition modes. The other mode is logico-scientific. The two modes are irreducible to each other and complementary. Each mode provides a distinctive way of ordering experience and constructing reality.

Causality plays a central role in both cognitive modes, but each defines causality differently. The logico-scientific mode looks for universal truth conditions, whereas the narrative mode looks for particular connections between events. The two modes of reasoning rely primarily on different communication codes to get their messages across, although they borrow freely from each other’s codes. The narrative code demonstrates the type of reasoning that understands the whole by integration of its parts. “Narrative meaning is created by noting that something is a ‘part’ of a whole and that something is a ‘cause’ of something else” (Richardson, 1995, p. 200). The meaning of each event is produced in its temporal position and its role in a comprehensible whole. While causality still plays a central role in logico-scientific explanation, it defines this differently. Logico-scientific explanation is abstracted from spatial and temporal contexts. This code demonstrates empiricist reasoning, the type of reasoning that “proves” statements.

Richardson (1995) conceded that “both modes are ‘rational’ ways of making meaning” (p. 201).

Elliot Mishler (1986), in his critical review of research interviewing, understands the process as a naturally occurring conversation (narrative discourse) between interviewer and interviewees. Mishler (1986) deplored the mainstream, traditional emphasis on standardization of the interviewing process, which he saw as reflecting “a restricted conception of the interview process” (p. vii), although he viewed interviewing, of itself, as a particularly valuable method of inquiry when seen as “speech event”. An interview, then, becomes a “joint product” of what interviewees and interviewers talk about together and how they talk with each other. The record of the interview made by the researcher, and then used by him or her in the work of analysis and interpretation, is a representation of that talk. Our theoretical assumptions and presuppositions about relations between discourse and meaning are embedded in that representation, and in the analytic procedures we apply to it. Analysis and interpretation are thus based on a theory of discourse and meaning.

Mishler’s (1986) aim is to make his readers aware of the “gap” he perceived as existing between research interviewing in its mainstream form, and naturally occurring conversations. What he particularly deplored in the practices of the mainstream tradition, was that the nature of interviewing as a form of discourse between speakers had been hidden from view by a dense screen of technical procedures. The idea of discourse had been suppressed. For example, questions and answers were regarded as analogues of stimuli and responses, rather than as forms of speech. The standardization of questions and interview behaviour is then supported by an elaborate technology of coding and statistical

analysis. The suppression of discourse is also accompanied by an equally pervasive disregard of respondents' social and personal contexts of meaning. Where issues of context are addressed they are treated as technical problems, rather than acknowledged as essential components of the meaning-expressing and meaning-understanding processes. "There is a cumulative suppression of stories through the several stages of a typical study: interviewers cut off accounts that might develop into stories, they do not record them when they appear, and analysts either discard them as too difficult to interpret or select pieces that will fit their coding systems" (Polkinghorne, 1988, p. 165).

The meanings of questions and answers in "speech event" interviews are contextually grounded. However, survey research in the mainstream tradition is a context-stripping procedure. Investigators "pretend that a variety of contexts that affect the interview process and the meaning of questions and answers are not present" (Mishler, 1986, p. 22). Traditional researchers tend to isolate the interview situation as a whole from both broad cultural and local subcultural norms and frameworks of meaning. Cicourel (1982, cited in Mishler, 1986) challenged the validity of survey research by asking, "do our instruments capture the daily life conditions, opinions, values, attitudes, and knowledge base of those we study as expressed in their natural habitat" (p. 24). Cicourel argued that investigators must seek to understand the respondents' utterances as employed and intended by the users within their socially organized context, and within the relationship of the interviewer and respondent. Later we will look at how, in the current research, an attempt has been made to develop systematic methods for the conduct and analysis of the interviews that "preserve their essential features as discourse" (Mishler, 1986, p. x).

A further endorsement for narrative was supplied by Donald Polkinghorne (1988), a practising psychotherapist. Polkinghorne claimed that the traditional research model, adopted from the natural sciences, was limited when applied to the study of human beings. Through his practical experience, Polkinghorne argued that “practitioners, perhaps are better commonsense epistemologists than academics” (p. x). When Polkinghorne examined what kind of knowledge practitioners used in their practice, he discovered that practitioners work with narrative knowledge. Narrative was defined by Polkinghorne as a cognitive process that “organizes human experiences into temporally meaningful episodes” (p. 1). Narrative was the primary scheme by means of which human existence is rendered meaningful. It [narrative] “displays the significance that events have for one another” (p. 13). From Polkinghorne’s viewpoint the study of the making of meaning was particularly central to the disciplines concerned with explaining human existence.

Polkinghorne (1988) advocated that the realm of meaning was “best captured through the qualitative nuances of its expression in ordinary language” (p. 10), and that the goal of research into the production of meaning was “to produce clear and accurate descriptions of the structures and forms of the various meaning systems” (p. 10). This can best be accomplished “by gathering examples of those systems’ expressions through self-reflection, interviews, and collection of artifacts” (p. 10). Narrative form referred to “a kind of organizational scheme expressed in story form” (p. 13), or a meaning structure that organizes events and human actions into a whole” (p. 18). The narrative is an organizing principle for human action. Sarbin (1986) is another researcher who believed that “human beings think, perceive, imagine, and make moral choices according to narrative structures” (p. 8). In everyday conversation nevertheless, the term narrative is equivocal. For

example, “it can refer to the process of making a story, to the cognitive scheme of the story, or to the result of the process - also called stories, tales, or histories (Polkinghorne, 1988, p. 13). For her own study Emden (1988) interpreted Polkinghorne’s emphasis on “scheme” and “whole” as the collective “stored wisdom of people’s individual stories” (p. 35).

As narrative is the method of inquiry chosen in the current research, we must attend to its salient characteristics, and in so doing argue “for the presence and value of *narrative*” (Richardson, 1995, p. 199). We note, therefore, that narrative is a condition of temporal existence. Polkinghorne (1988) and Richardson (1995) both draw our attention to the way in which narrative allows humans to make sense of their temporal worlds. “People everywhere experience and interpret their lives in relation to *time*” (Richardson, 1995, p. 207). This is not surprising as the experience and interpretation of time is a basic and dominant theme of human reality (Polkinghorne, 1988). Paul Ricoeur’s (1984-1986) work on time and narrative provided a thorough investigation of the way the narrative form organizes language to reflect the human experience of time. Ricoeur’s thesis is that the coexistence of the temporal nature of the human being and the activity of narrating a story are not accidental, but represent a “transcultural form of necessity” (Richardson, 1995, p. 208).

Richardson (1995) argued that narrative provides access to the uniquely human experience of time in five sociologically significant ways: the everyday, the autobiographical, the biographical, the cultural, and what he terms “the collective story”. Although these ways are presented as analytically separable, in practice they can overlap and intersect, as for example when an interviewee “tells” his or her autobiography, that the interviewer “writes

up” as a biography, but “presents” as a part of a more general cultural or collective story. In the current research, the researcher has followed this same path, that is, the recording of a particular slice of the interviewee’s autobiography, which has been “written up”, and presented as part of the collective public health story of the citizens of Victoria. Polkinghorne (1988) observed that the temporality of human experience is punctuated not only according to one’s own life but also according to one’s place within the long-time spans of history and social evolution. Narrative is the mode of meaning construction that displays these various experiences of time.

Individuals construct past events and actions in personal narratives to claim identities and construct lives. Crites (1986, cited in Polkinghorne, 1988) addressed the temporal dimension of story making in terms of its importance for personal identity formation. “One’s personal story or personal identity is a recollected self in which the more complete the story that is formed, the more integrated the self will be” (p. 106). Identity, recollected out of the past, is a depth dimension of the self that gives the self character. Identity includes also a construction of a future story that contains the “I” of the person. There needs to be some continuity between past and future stories. This might lead to problems in that a past story is a recollection of what has already been, while a future story, although it needs to be a continuation of the past, requires an open and adaptive character. Appropriating the past and anticipating the future require different narrative strategies if one is to avoid the unhappiness, or loss of identity, resulting from an appropriation which is not recollective, integrating, and self-discovering, or the hopelessness resulting from a failure to project a hopeful story about one’s future life. In the current research it is the case that several participants were unable to project a hopeful future for themselves within

the context of the story they were telling. This possibly influenced their decisions later in removing themselves from the context of the story.

In any research it is important to be sensitive to the *storied* quality of much qualitative data. Such data can be conceptualized as the ways in which social actors produce, represent, and contextualize experience and personal knowledge through narrative and other genres (Coffey & Atkinson, 1996). The collection of stories and narratives in qualitative research extends the “interpretive turn” in social science. A narrative account is a story of a sequence of events that has significance for the narrator and his or her audience. Denzin (1989, cited in Coffey & Atkinson, 1996) observed that “the story (as do all good stories) has a beginning, a middle, and an end, as well as a logic that (at least) makes sense to the narrator” (p. 55). Sarbin (1986) defined narratives as “Coterminous with *story* as used by ordinary speakers of English” (p. 3). He agreed with Denzin that a story is a symbolized account of actions of human beings that has a temporal dimension. The story is held together by recognizable patterns of events, called plots, and central to the plot structure are human predicaments and attempted resolutions. Closer to the present enterprise, narratives and stories can be solicited during research interviews. Mishler (1986) in particular considered interview responses in terms of the stories they embodied. Precisely because it is a form of discourse that is known and used in everyday interaction, the story is an obvious way for social actors, in talking to strangers (such as the researcher) to retell key experiences and events.

In his *Introduction to the Structural Analysis of the Narrative*, Barthes (1966) wrote about the centrality of narrative in the lives of people. In the first place the word “narrative”

covers an enormous variety of genres, as if any material is suitable for the composition of the narrative. “It is present in myth, legend, fable, short story, epic, history, tragedy, comedy, pantomime, painting” (Polkinghorne, 1988, p. 14). Narratives perform significant functions. At the individual level, people have a narrative (story) of their own lives which enables them to construe who they are and where they are headed. At the cultural level, narratives serve to give cohesion to shared beliefs and to transmit values. Coffey and Atkinson (1996) supported this belief that stories serve a variety of functions. Social actors often remember and order their careers or memories as a series of narrative chronicles, that is, as a series of stories marked by key happenings. Similarly, stories and legends are often told, and retold, by members of particular social groups or organizations, as a way of passing on a cultural heritage or an organizational culture. Tales of success or tales of key leaders/personalities are familiar genres with which to maintain a collective sense of the culture of an organization. In the case of the present research, it will become apparent that, in the process of telling their stories, the participants have a perspective about their newly formed organization that has been informed by their earlier experiences in their organizations of origin.

Polkinghorne (1988) commented on the contribution of studies such as those of Shiebe (1986) to the notion that “people conceive of themselves in terms of stories” (Polkinghorne, 1988, p. 107). Shiebe’s (1986, cited in Polkinghorne, 1988) idea is that people undertake adventures in order to construct and maintain satisfactory life stories. In terms of a psychological biography, a life lived without adventures and on a single plane is insufficient as a story; it does not go anywhere and does not move. Narrative enrichment occurs when one retrospectively revises, selects, and orders past details in such a way as to

create a self-narrative that is coherent and satisfying, and that will serve as a justification for one's present condition and situation.

Emden (1998) also provided support for narrative as a research method. She drew upon the theoretical perspectives of Bruner (1987) and Roof (1993) to support her own understandings of nursing scholars and scholarship. Bruner (cited in Emden, 1998) argued that we become the autobiographical narratives by which we tell about our lives. "A life is not 'how it was' but how it is interpreted and reinterpreted, told and retold" (p. 36). Bruner cannot imagine a more important research project than one which addresses itself to the development of autobiography. He stresses as well that people's stories "mesh" within a community of other stories, much as the interviewees from each hospital in the study tell stories that can be seen to 'mesh' together with those of others from their hospital of origin. They do this because they share certain 'deep structures' or contextual understandings. The reflexivity of self-narrative nevertheless creates dilemmas. The instability of these accounts makes them highly susceptible to cultural, interpersonal, and linguistic influences so that all verification criteria turn "slippery". In a later paper, Bruner (1990, cited in Epston & White, 1992) mentioned the need for people to engage actively in the performance of unique meaning as they resolve the gaps, inconsistencies, and contradictions in their stories.

Roof (1993) agreed with Richardson (1995) that the wide range of "logico-scientific" approaches are possibly no more advanced than story-telling as a research method. Roof's strategy for the promotion of narrative is to put forward a case for it within a post-modern context. He regarded the telling and hearing of stories to be a valuable means of

understanding the nuances of people's (spiritual) lives within the wider cultural narratives of the times. People's stories are never just their stories. Stories connect us with the larger stories, with the cultural narratives that shape our shared meanings. The usefulness of the theories of Bruner (1987) and Roof (1993) for Emden (1998) is that together, their theories take account of the meaningfulness of individual and cultural stories within a narrative research tradition. In the current research it will be demonstrated that people's judgements and perspectives about the events they are retelling are very much influenced by larger cultural narratives, specifically those of their hospitals of origin.

Sarbin (1986) described narrative psychology as a viable alternative to the positivist paradigm. In his collection of essays, each of which makes a case for the storied nature of human action, Sarbin exemplified the use of narrative as a root metaphor to underline its universal popularity. "Novelists, dramatists, poets, essayists, and film makers - storytellers all - have continued to provide insights about human motives and actions, even during the hundred years that human conduct has been examined by scientific psychology" (p. vii).

A number of other theorists (for example, Epston & White, 1992; Czarniawska-Joerges, 1995; Wiltshire, 1995 and Barry & Elms, 1997) have further examined the place of narrative in the social sciences. Czarniawska-Joerges (1995) argued that scientific and non-scientific literature might have more in common than anybody wishes to admit. "Science', is not separated from 'narrative' by an abyss" (p. 14). Nevertheless, she questioned whether it was enough to reintroduce narrative knowledge into a research tradition imbued with logico-scientific knowledge. The foil for theorists such as Czarniawska-Joerges (1995) comes from the suggestion of Epston and White (1992) that it is the meaning we attribute to experience, that is the constitutive of our lives, that has encouraged social

scientists to explore the nature of the frames that facilitate the interpretation of experience. It is the narrative, or story, that provides the primary frame for this interpretation. Epston and White (1992) argued that it is through our own stories, or those about the lives of others, that we make sense of our experience. These stories also largely determine which aspects of experience we select out for expression. As well, these stories determine real effects in terms of shaping people's lives.

Epston and White (1992) following Bruner's (1986) "dual landscapes", proposed that persons live their lives through landscapes of action and landscapes of consciousness. In landscapes of action, events are linked together sequentially by past, present, and future, and according to specific plots in a text. Landscapes of consciousness refer to the perceptions, thoughts, speculation, realizations and conclusions which occur as the events and plots unfold through the landscape of action. Epston and White (1992) also alluded to cultural determinacy in narrative. There is a canonical dimension to the stories that people live by because they are co-authored within a community of persons. In this, these researchers agreed with other theorists such as Roof (1993) and Emden (1998) that our stories are inevitably framed by our dominant cultural knowledge. But they do point out that there is indeterminacy within this cultural determinacy. The stories that people live by are full of the gaps and inconsistencies noted by Bruner (1986).

Our own research is based within the hospital and medical community. Wiltshire (1995) welcomes the recent attention given to narrative within medicine. Increasingly nurses and doctors are seeing their own practices and professional commitments in terms of story and narrative, which are held up as an alternative model of practice to science and modes of

reasoning which take the physical or biological sciences as a model. Narrative is emphasized, both by the spoken accounts by patients and doctors, as an essential tool in the understanding of suffering as a human experience. Narratives organize Bruner's (1991, cited in Wiltshire, 1995) "rich and messy domain of human interaction" into structure (P. 78). Organizing events into a narrative structure seems in effect to be the same process as the drawing out of meaning among these events. It is highly possible that a health community able to commit to narrative in the assessment and treatment of patients can, by using the same process, commit to examining its own professional health and well-being (physician heal thyself). In terms of our own study, narrative is the methodology of choice because we are looking for the meanings that each of the persons involved in the research ascribed to the drama in which they have participated. Narrative is the road we must travel in order to fully flesh out their stories. The purpose of the narrative interviews is to see how the respondents "impose order on the flow of experience to make sense of events and actions in their lives" (Reissman, 1993, p. 2).

The Self in Research

We bring our own stories to the research process, and the present researcher is no exception to this rule. "Many researchers now accept that they are not disinterested but are deeply invested in their studies, personally and profoundly" (Bullough & Pinnegar, 2001, p. 13). Berg and Smith (1985) emphasized that all researchers have a stake in their research which, at a minimum, can be understood as "the pursuit of the researcher's interests with either the acquiescence or active participation of a social system" (p. 26).

The researcher here also has a story to tell about her own involvement in this study. Mishler (1986) maintained that one of the fundamental questions all students of interview narratives must ask is “What are the effects on the production of a narrative of the respondent’s “story”, of the interview as a particular context, and of the interviewer as questioner, listener, and participant in the discourse?” (p. 82). That portion of Mishler’s question which deals with the interviewer can be likewise defined as “the quality of an investigator that affects the results of observational conversation (Peshkin, 1988, p. 267). This investigator feels obliged to disclose that she has come to the present research with a past history of organizational involvement (in a different organization to the one in which she has based her research), with personal ties to an individual in the organization under scrutiny (who is included as an interviewee-participant), and with a perspective coloured by education, training and many years of professional practice as an educational, developmental, and counselling psychologist.

The researcher’s own narrative encompasses more than twenty years working as a psychologist in the State Education Department, a bureaucracy where there were repeated (and frequent) organizational restructurings, generally determined by changes in State governments, each with its own political persuasion. The educational psychologists, of which the researcher was one, worked within professional guidelines at the periphery of the school system, but came, over time, to represent a minority group with almost no industrial influence. Nevertheless, the psychologists retained their professional status and were seen as the “great survivors”, managing to maintain a presence in spite of dwindling numbers, loss of political power, loss of control over their own destinies, and even loss of an independent work environment. In the 1970s, when the researcher joined the “psychology

branch” of the Victorian Education Department, it was the largest employer of teacher-trained psychologists (guidance officers) in the State of Victoria. Psychologists, together with teacher-trained social workers and welfare workers were organized within a Special Services Division and administered by an independent central administration and branch centres located throughout the metropolitan and Victorian-country regions (Lapidus, 1992). By the early 1990s, the psychologists had been decimated in number and had undergone restructuring within a variety of regionally-based arrangements, for example, school support centres, until they were finally geographically located in schools and placed directly under the control of school principals in district or network arrangements. While their continued survival might be primarily attributable to the ever-pressing need for psychological support in schools, working in this emotionally unstable environment had an enormous influence on the researcher’s working life, and on her search for and choice of, research topic.

Individuals make sense of their own experience by casting it in narrative form and “this is especially true of difficult life transitions and trauma” (Reissman, 1993, p. 4). Initially, the researcher was interested in telling the stories of her own colleagues. She had witnessed trauma and the struggle to complete transitions amongst the psychologists and social workers in her own working environment where, over time, she had closely observed their responses and behaviours, as well as her own, to the disruptive effects of restructuring. The researcher’s interest in telling the stories of people in her own section of the bureaucracy was stimulated when, as a potential doctoral student, her attention was drawn to David Noer’s (1993) *Healing the Wounds*, unavailable at that time in Australia. Unfortunately, in

terms of a desirable research environment, the researcher's own workplace was experiencing a period of relative stability at the time of her enrolment in Doctoral studies.

In 1996, the attention of the researcher was directed to the amalgamation of the Alpha and Beta Medical Centre. For more than fifteen years, the researcher had maintained a close association with a senior health practitioner working in one of the hospitals involved in this amalgamation. As a narrative researcher the prospect of completing her research at this venue was an extremely attractive proposition for several equally valid reasons, for example, the effects of the recent amalgamation were then occupying a salient place in people's minds and hearts. Moreover, the researcher's relationship guaranteed access to senior clinicians and administrators who might otherwise have been reluctant to tell their stories and reveal their concerns to an external researcher. A minor disadvantage which emerged early on in the course of the interviews was the interviewees' assumption that, as she was the partner of a clinician, the researcher had a full understanding of medical and hospital practice and personnel, including some complicated medical terminology. Clarification had to be sought in some instances.

The researcher was aware of a difficult issue which might surface in the research, that is, the intrusion of subjectivity. The literature suggested dealing with subjectivity as "a persisting aspect of social research" (Peshkin 1988, p. 167). It can be viewed as "an amalgam of the dispositions stemming from one's class, statuses, gender, and values" (p. 167). Peshkin (1988) tells us that in actual practice, as opposed to the abstract discussion of social science, researchers "tack between alternating - even simultaneous - understanding and awareness of their own project in terms of the realist's objectivity and the idealist's

subjectivity” (Peshkin, 1988, p. 268). The orientation of the truly idealistic researcher is derived from a recognition of the impossibility of value-free research, the consequent inevitability of researcher-object interaction in social research, and “the sense that subjectivity is the salt of creativity” (Peshkin, 1988, p. 268).

As a mainstream psychology undergraduate in the 1970s, the researcher was taught that personal involvement in their research renders the work of investigators somehow unscientific or illegitimate. The assumption in this teaching was that somewhere there is a social scientist who has no personal involvement, or whose involvement has no influence on his or her work. However, theorists such as Berg and Smith (1985) believed that this latter view was a myth. “That personal factors penetrate all points of the research process is a matter of record” (Peshkin, 1988, p. 268). Moreover, Reinhartz, (1979, cited in Peshkin, 1988) noted that as a researcher, she chose to study a mental hospital because of “the personal pain of having friends of my own recently hospitalized for psychiatric problems” (p. 268). In the task of seeking an area and site for research, both the researcher’s conscious and unconscious needs seek fulfillment. The researcher in the current study clearly was drawn to a subject which resonated with, and gave substance to, her own employment history and to unresolved aspects of the trauma she had personally experienced within her own work setting.

The researcher’s subjectivity does not end with choice of research subject. It is almost certain that our personal proclivities do more than incline us to investigate certain problems. They lead us to take sides (Peshkin, 1988). In her usual school-based work with children, the researcher was aware of her leanings towards “speaking for the children” who

sometimes experience marginalization and sidelining when decisions are made for them within families and schools; or in her private practice, for the “victims” of workplace accidents trapped in a compensation process which is practised with relatively little compassion for the applicants. In the present research there was from the outset almost certainly a bias in favour of one hospital involved in the amalgamation, and against the process in general. In matters about his employment situation, the researcher’s partner was normally fairly reticent. Nevertheless, in the period of time leading up to and beyond the amalgamation, occasionally it was difficult for him to remain silent about his concern with possible political faction fighting, which seemed to favour one hospital over the other. As well, it was impossible not to sense and share in his feelings of anxiety and powerlessness about the processes of the amalgamation.

Narrative and Language

Ultimately, the production and understanding of narratives is a function of the capacity of human beings to produce language. Polkinghorne (1988) reviewed the acquisition of language in human organisms which, he reminded us, must occur at a critical period of development early in life. Language is a factor that enables us to express the unique order of existence that is the human realm, because it serves as a medium through which we express the world as meaningful. The researcher has declared the influence of her own history on her orientation to the present investigation. In the study the participants, by virtue of education, strength of personality, commitment to their chosen professions, wealth of experience, feelings of frustration, and so forth, were particularly eloquent in their own descriptions of the unique survivor experiences they were contributing to the study.

The narrative material for the current research is derived from interviews which are the expressions of discourse events. The principle brought to this discourse activity is that people will strive to organize their temporal experience into meaningful wholes and to use the narrative form as a pattern for uniting these events into unfolding themes. As Mishler (1986) noted, soliciting stories from respondents is not a problem for the interviewer. Moreover, narratives are a recurrent and prominent feature of accounts offered in all types of interviews so long as we invite respondents “into our work as collaborators, sharing control with them, so that together we try to understand what their stories are about” (p. 249).

Discourse events have their own structure. The position taken by Pokinghorne (1988) in general is that language does not have an innocent and transparent function in knowledge creation; that its grammatical, rhetorical, and narrative structures constitute (that is, impose form upon) the subjects and objects that appear in the order of meaning. “Linguistic forms have as much reality as the material objects of the physical realm” (p. 158). Linguistic forms filter and organize information from the physical and cultural realms and transform it into the meanings that make up human knowledge and experience. Knowledge of the realm of meaning is gained through interpretive or hermeneutic procedures.

Certain conventions of discourse organization cover the formation of various kinds of communications. These conventions are similar in function to grammatical rules. The same principle that describes the creation of excess meaning by combining words into sentences holds for the creation of additional meaning when individual sentences are

combined into discourses. These are often called “texts”, even though they may be spoken as well as written.

Human expression requires the competency to use the many principles that produce discourse meaning by combining elements into larger units. The communication of this narrative meaning requires a message in the form of narrative discourse. In addition, it requires for its appearance, the presence of the hearer (the researcher) and speaker (the interviewee). The hearer and speaker draw on communal conventions in the mutual expectation that each member of the communication community symbolizes meaning according to the same set of transforming covenants. The successful transmission of any message requires competence in the use of the whole system of communication. Jakobson (1960, cited in Polkinghorne, 1988) is one theorist whose work contributed to the shift from linguistic models of words to communication models of discourse. His theory of communication holds that whether we are considering ordinary conversation, a public speech, a letter, a poem, or a narrative, we always find a message that proceeds from an addresser or sender to an addressee or receiver. The message communicated is dependent on three factors: a contact, a code, and a context.

Mishler (1986) acknowledged the pervasive influence of research interviewing in our daily lives. “Much that we claim to know about individuals’ attitudes, beliefs, and values is based on their responses to questions we ask them in our studies” (p. 233). However, Mishler also alerted us to the inappropriateness of the standardized form of interviewing which has been the hallmark of the dominant mainstream tradition. This form of inquiry has been accompanied by an almost total neglect of the intertwined problems of language,

meaning, and context - problems that are critical to understanding how interviews work. Mishler's perspective, which regarded interviews as a discourse between speakers, allows these problems to come forward and become central topics for interview research. "This is done by treating respondents' answers to questions as stories or narratives, and by applying methods of narrative analysis" (p, 234).

As indicated in an earlier section, Mishler (1986) clearly differentiated between a mainstream traditional frame of reference for interviewing, and a narrative interpretive frame. In the mainstream tradition the idea of discourse is suppressed and questions and answers are framed as stimulus-response. The analyst maintains a "correct" and "objective" distance from the respondent. Respondents' stories remain unrecorded. They are seen as irrelevant to the specific aims of the specific questions. The research methods employed are neutral. The instruments for recording data and describing reality do not in themselves change reality. The world, as it is defined within the mainstream tradition, is standardized and divorced from personal and local contexts of relevance, with its meanings defined and controlled by the researcher. While the confidentiality of the interviewee is assured, respondents have no opportunity to comment on the researcher's interpretations of their words and intentions. The standard interview presents respondents with a predetermined scheme of topics, definitions of events, and categories for response and evaluation, all framed and specified by the interviewer, who then determines the adequacy and appropriateness of the response. The interviewer, then, defines the meaning of the responses (Mishler, 1986).

The situation is vastly different when the interview is seen as a speech event, and where there is no reliance on a statistical analysis of aggregated responses. In this scenario issues of context are integral to the meaning being sought. Within the particular interview context, a give and take situation unfolds where “respondents are invited to speak in their own voices, allowed to control the introduction and flow of topics, and encouraged to extend their [own] responses”(Mishler, 1986, p. 69), and the interviewer works jointly with the respondent to uncover the meaning of the event. In general, in the current research, there was little need for the interviewer to encourage interviewees to extend their responses further as interviewees were generous with their output of information.

An interview conducted within a narrative interpretive frame empowers the respondent to speak in her/his own voice and to tell stories. The respondent is seen as a competent observer who gives informed consent to their participation in the interview process. Interviewer and respondent come to view each other as significant others, with the respondent acting as a “collaborator” in the study. He or she is a full participant in the development of the study, and in the analysis and interpretation of the data. Analysts do not have the option of distancing themselves from the talk. In this framework respondents are active subjects of great interest and importance, whose cooperation and insights are essential to the study. In the present study there has been an attempt to capture these insights and characterize them as themes, and then to convey these to the reader. Mishler (1986) also recognized that respondents were advocates in their own interests. Through their narratives, respondents may be moved to the possibilities of action in their own interests. Mishler (1986) reported that “for some, the [narrative] interview was the first

step toward gaining a voice” (p. 127). For example, this research gave one interviewee a focus for exploring how much she missed her network contacts.

Lakoff and Johnson (1980) took up Mishler’s (1986) view of the need to involve interviewer and respondent in a collaborative enterprise, when they claimed that truth is relative to individual understanding. The ramification of this is that there is no absolute standpoint from which we may obtain absolute objective truths about the world. This does not mean that there are no truths; it means only that “truth is relative to our conceptual system, which is grounded in, and constantly tested by, our experiences and those of other members of our culture in our daily interactions with other people and with our physical and cultural environments” (p. 193). Meaning is not cut and dried. Meaning is always “a matter of what is meaningful and significant *to* a person” (Lakoff & Johnson, 1980, p. 224). What is significant for a person will not depend on rational knowledge alone, but on that person’s past experiences, values, feelings, and intuitive insights. It is a matter of imagination and of constructing coherence. Lakoff and Johnson (1980) pinpointed the difficulties which can occur when people who are talking do not share the same culture, knowledge, values, and assumptions. In this situation mutual understanding can be especially difficult. Such understanding becomes possible however through the negotiation of meaning. To negotiate meaning with someone, you have to become aware of, and respect, both the differences in your backgrounds and when these differences are important. You need enough diversity of cultural and personal experience to be aware that divergent world views exist and what they might be like, so that “when the chips are down, meaning is negotiated, [and] you slowly figure out what you have in common, what it is safe to talk

about, how you can communicate unshared experience or create a shared vision” (p. 231-232).

Lakoff and Johnson (1980) stressed that in interpersonal communication, you need patience, a certain flexibility in world view, and a generous tolerance for mistakes, as well as a talent for finding the right metaphor to communicate the relevant parts of unshared experience, or to highlight the shared experiences while deemphasizing the others. There are several examples in the current research of experiences being communicated metaphorically by respondents, as they attempt to create and give emphasis to an experience or vision. In one instance, a respondent emphasized a point about the survivors in her hospital who “started getting stressed when they saw all their compatriots being thrown out of their positions. When all their friends left, when they saw seven hundred out of two thousand leave, this had a major impact on them. Lots of relationships were gone”. This respondent described metaphorically how the people who had lost their jobs were perceived as having been “thrown on the scrapheap of life and sold down the river” in the wash up of positions that occurred following the amalgamation of the two hospitals (the Interviews). As this example demonstrates, metaphorical imagination can be a crucial skill in creating rapport and in communicating the nature of unshared experience. This skill consists, in large measure, of the ability to bend your world view and adjust the way you categorize your experience. Nevertheless, it pays to remember that “problems of mutual understanding are not exotic; they arise in all extended conversations where understanding is important” (Lakoff & Johnson, 1980, p. 231).

Oakley (1981) is another researcher who examined “the gap between textbook recipes for interviewing and her own experiences as an interviewer” (p. 30). Interviewing, which is one means of conducting a survey, is perceived by Oakley as occurring traditionally within a masculine paradigm where the interview is not seen simply as a conversation but as, rather, a pseudo-conversation. That is, Oakley categorized the traditional interview as a one-way process where “the interviewer elicits and receives, but does not give information” (p. 30). Textbooks advise interviewers to adopt an attitude towards interviewees which allocates the latter a narrow and objectified function as data, and where the interviews have no personal meaning. Their meaning tends to be confined to their statistical comparability with the data obtained from other interviews.

The usefulness of Oakley (1981) to the current research is not that she is focused on feminist concerns and a feminist agenda, but that her writing reflects the major differences in approach between the mainstream or traditional paradigm of interviewing, and the narrative approach as already described by Mishler (1986), while adding her own perspective on the differences. For example, she points out that in the traditional interview, both interviewer and interviewee must be “socialized” into the correct interviewing behaviour. Therefore, one piece of behaviour that properly socialized respondents do not engage in is asking questions back. The rule remains that the interviewer is there to obtain information and the focus must be put back on the respondent, not the interviewer. For the interviewer to indicate that he or she has information (or to be possessed of information the interviewee wants) is to acknowledge bias, and bias clearly invalidates the scientific claims of such research. To avoid contamination of the interview material caused by the interviewee’s responses to interviewers’ attitudinal stances, both interviewers and their

interviewees must remain depersonalized participants in the research process. It is a further characteristic of the traditional research paradigm that the relationship between the interviewer and the interviewee remains hierarchical. It is the body of expertise possessed by the interviewer that allows the interview to be conducted successfully. Oakley's position is that the entire paradigmatic representation of "proper" interviews in the methodology textbooks, "owe a great deal more to a masculine social and sociological vantage point than to a feminine one" (1981, p. 38).

The paradigm of the "proper" interview appeals to such values as detachment, hierarchy, and "science" as an important cultural activity which takes place over people's more individualized concerns. The polarity of "proper" and "improper" interviewing is viewed by Oakley (1981) as an almost classical representation of the widespread gender stereotyping which has been shown to occur in modern industrialized societies. Women are characterized as sensitive, intuitive, incapable of objectivity and emotional detachment, and immersed in the business of making and sustaining personal relationships. Men are superior through their capacity for rationality and scientific objectivity and are thus seen to be possessed of an instrumental orientation in their relationships with others. Interviewers define the role of interviewees as subordinates; extracting information is more to be valued than yielding it; the convention of the interviewer-interviewee hierarchy is a rationalization of inequality; what is good for interviewers is not necessarily good for interviewees.

Apposite to the current research, Oakley (1981) looked at the textbook paradigm and arrived at a similar position to the theorists reviewed on the preceding pages. For her it has become clear that the goal of finding out about people through interviewing "is best

achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own identity in the relationship” (p. 41). Interestingly, she pointed out that repeated interviewing is not much discussed in the methodological literature: the traditional paradigm is of an interview as a “one-off” affair. Common sense would suggest that an ethic of detachment on the interviewer’s part is much easier to maintain where there is only one meeting with the interviewee. Conversely, Oakley (1981) suggested that in the case of anthropology or “repeated interviewing” in sociology, the research cannot proceed without a relationship of mutual trust being established between interviewer and interviewee. This inevitably changes the interviewer’s attitude to the people he or she is studying. As well, the formulation of the interviewer role changes dramatically from being a data-collecting instrument for researchers to being a data-collecting instrument for those whose lives are being researched. The mythology of “hygienic” or scientific research, with its accompanying mystification of the researcher, and the researched as objective instruments of data production, has been replaced by the recognition that personal involvement is more than dangerous bias - “it is the condition under which people come to know each other and to admit others into their lives” (Oakley, 1981, p. 58).

Narrative as Metaphor

And he said unto them, Ye will surely say unto me this proverb,

Physician, heal thyself;

whatsoever we have heard done in Capernicum, do also here in thy country

(Luke 4:23).

This piece of text from the new testament supplies the central metaphor for our study. “The essence of metaphor is understanding and experiencing one thing in terms of another” (Lakoff & Johnson, 1980, p. 5).

The New Testament can be seen as a work of historical fact, or as fiction. By its use of parables and anecdotes it supplies a methodology for instructing the reader through the tales of weaknesses and strengths exhibited by the people contained in its pages. Its storytelling methodology revolves around the stresses and strains that emerge in individuals when they are struggling to maintain lives of purity or moral rigour. The metaphor is an economical and valuable tool for understanding an event which might otherwise elude us. Making metaphors has the capability of pulling great quantities of fragmented data together into a single descriptive image (Bright, 2000).

How can the metaphor cited above pull together the data contained in the present study? What the researcher is seeking through metaphorical understanding is an enhanced appreciation of the events which are being relived through the narrative interviews. If the choice of metaphor has been effective, it will operate at more than one level and convey

more than one understanding to the reader. For example, through the metaphor, the researcher wants to convey the idea of an environment which has something to do with medicine and healing. The researcher also wants to establish that there are people (the interviewees) who function within this medical environment such as doctors, allied health workers and medical administrators. At another level, the metaphor conveys the sense that there is something awry or “sick” in the environment which is being revealed in the study, and that this sickness can be identified and described (survivor symptoms such as anxiety, guilt and anger). The metaphor establishes that it is necessary for the people working within this medical community to search for, and initiate their own healing, through processes of effective organizational change (“physician heal thyself”). Moreover, the metaphor suggests that there already exists a source of knowledge, a model from which these professionals can draw, in order to initiate the self-healing that needs to occur (Luke 4:23; David Noer, 1993).

Metaphor can create new meaning, create similarities, and therefore define a new reality. Morgan (1986) reminded us that many of our taken-for-granted ideas about organizations are metaphorical, even though we may not recognize them as such. For example, we frequently talk about organizations as if they were machines designed to achieve predetermined goals and objectives, and which should operate smoothly and effectively. As a result of this type of thinking we often attempt to organize and manage them in a mechanistic way, forcing their human qualities into a background role. Conversely, organizations may be seen as complex, ambiguous, and paradoxical. The real challenge is to learn to deal with this complexity. By building on the use of metaphor, which is basic to our way of thinking generally, Morgan (1986) believed that we have a means of enhancing

our capacity for creative yet disciplined thought, “in a way that allows us to grasp and deal with the many-sided character of organizational life” (p. 17). “Metaphors are seen as a fundamentally important way to learn” (Aupperle & Karimalis, 2001, p. 24). They can be seen as “the cognitive lens we use to make sense of all situations, especially the organizations we work in and through” (Aupperle & Karimalis, 2001, p. 25). Our existing theories and explanations of organizational life are based on metaphors that lead us to see and understand organizations in distinctive, yet partial, ways. We can see this in the metaphor appropriated for the present study, which views the organization as suffering from survivor symptoms and therefore “sick”. The danger here is of overlooking the resilience already existing in the members of this organization, which can be utilized to deal effectively with healing and the change process.

Lakoff and Johnson (1980) affirmed the metaphor as pervasive in everyday life, not just in language, but in thought and action as well. “If we are right in suggesting that our conceptual system is largely metaphorical, then the way we think, what we experience, and what we do every day is very much a matter of metaphor” (p. 3). It is this more pervasive conceptualization of metaphor that informs the current study where the metaphor “physician heal thyself” (Luke 4:23) guides our thinking about the participants (a group of medical and allied health professionals and administrators) who are working within the context of a health care system much in need of healing, and to which they are responding by displaying symptoms (sickness) in the form of survivor syndrome. As well, the metaphor conveys a more optimistic and hopeful message to the participants in the study, one expressed most aptly by David Noer (1984). That is, we learn about the changing nature of the work contract, the ill-management of change processes, and the extent of

survivor sickness. We also learn that it is possible, but only from within ourselves, from our own inner strength and ability, to respond appropriately to a dynamic and changing work environment, and that useful healing of survivor syndrome can take place.

Lakoff and Johnson's (1980) use of metaphor is consistent with the belief expressed by Morgan (1986) that metaphor is essential to human understanding and as a mechanism for creating new meaning and new realities in our lives. Rather than existing as a device for embellishing discourse, the use of metaphor implies a way of thinking, and a way of seeing, that pervades how we understand our world generally. Morgan (1986) noted that "metaphor exerts a formative influence on science, on our language and on how we think, as well as on how we express ourselves on a day-to-day basis" (p. 12-13).

Lakoff and Johnson (1980) focused on how an account of metaphor can call into question the accepted assumptions about truth, meaning and understanding that are grounded in the Western philosophical tradition of objectivism. They rejected what they label as the myths of objectivism and subjectivism in their discussion of metaphor. The myth of objectivism, they said, inadequately accounts for human understanding, "and everything dealt with by the human sciences". Without objectivism we would be left only with a "radical subjectivity, which denies the possibility of any scientific 'lawlike' account of human realities (Lakoff & Johnson, 1980, p. 223). The myth of subjectivism, however, misses that our understanding, even our most imaginative understanding, is given in terms of a conceptual system that is grounded in our successful functioning in our physical and cultural environments. Lakoff and Johnson (1980) recognized that in this belief they were

at odds with most of the Western philosophical tradition, “which has seen metaphor as an agent of subjectivism and, therefore, as subversive of the quest for absolute truth” (p. 196).

Within Lakoff and Johnson’s (1980) experientialist world, understanding emerges from interaction, from constant negotiation with the environment and other people. We understand our experiences directly when we see them being structured coherently in terms of gestalts, or structures, that have emerged precisely from our interaction with, and in, our environment. We understand experience metaphorically, when we use a gestalt from one domain of experience to structure experience in another domain. It is this richness of perspective that is brought to the current research, from the participants’ direct interaction with their environment and the sense they are attempting to make of it. From the experientialist’s perspective, truth depends on understanding, which emerges from functioning in the world. It is through such functioning that the experientialist alternative meets the objectivist’s need for an account of truth. What is missed in the objectivism and subjectivism accounts “is an interactionally based and creative understanding” (Lakoff & Johnson, 1980, p. 231).

Lakoff and Johnson (1980) emphasized the importance of metaphors in the negotiation of meaning between people. To negotiate meaning people need an awareness of, and respect for, their differences, a diversity of cultural and personal experience, tolerance for mistakes, and a talent for finding the right metaphor to communicate the relevant parts of unshared experiences while deemphasizing the others. The participants in the study manage to convey a heightened depth of meaning when they use terms such as “medical cowboys” to convey a sense of a powerful group of doctors, or make reference to an organization which

has become “an open wound” to demonstrate how the organization has become a painful place to work. Metaphorical imagination is a crucial skill in creating rapport and in communicating the nature of unshared experience. Moreover, just as we seek out metaphors to highlight and make coherent what we have in common with someone else, so we seek out personal metaphors to highlight and make coherent our own pasts, our present activities, and our dreams, hopes, and goals as well. A large part of self-understanding is the search for appropriate personal metaphors that make sense of our lives. This involves the constant construction of new coherences in your life, coherences that give meaning to old experiences. “The process of self-understanding is the continual development of new life stories for yourself” (Lakoff & Johnson, 1980, p, 233).

Coffey and Atkinson (1996) suggested that in narrative analysis, form and content can be studied together. These researchers are concerned with the way narrative can illuminate how informants use language to convey particular meanings and experiences. A broadly semiotic approach can lead us to look at specialized vocabularies in our data. It is always important to pay close attention to how members of particular groups or communities use ordinary language in special ways, or use local specific variants. The organization of cultural categories through linguistic resources is a fundamental topic for virtually any kind of qualitative research. Likewise it is important to examine interviews and other kinds of data in terms of their status as accounts. “They [the informants] may be giving accounts that justify, legitimate, excuse, and so on” (Coffey & Atkinson, 1996, p. 84). This appeared to be the case with one interviewee from the Beta Hospital group. This interviewee spoke about the new network structure as a “shake-up of the industry by radically varying its form of governance. Hospitals remain viable, individual entities,

within the enveloping aegis of the Network. Now, with the Network structure, they [the hospitals] have to cooperate. This has meant that the Network can facilitate an alliance between hospitals. That couldn't happen before" (the Interviews). The account given by this particular interviewee can be seen within a perspective of "legitimizing the Network".

A metaphorical statement reduces two terms to their shared characteristics, enabling the linguistic transference of one to another. For the purposes of qualitative analysis, we need to consider metaphor in a broader context. In the analysis of interactional or textual data, we might be concerned not only with how metaphors are structured but also with the ways they are used and the ways in which they are understood. In terms of data analysis, metaphors can be considered in a number of different ways. For example, we can explore the intent (or function) of the metaphor, the cultural context of the metaphor, and the semantic mode of the metaphor. The use of metaphor by social actors in their interactions with one another, and in the course of research interviews, is revealing. This is particularly the case if we think of metaphors in terms of their social or cultural contexts. Metaphors are grounded in socially shared knowledge and conventional usage. Particular metaphors may help to identify cultural domains that are familiar to the members of a given culture or subculture; they express specific values, collective identities, shared knowledge, and common vocabularies. "How metaphors are structured and performed by social actors can reveal the taken-for-granted usage of metaphor and may prompt an analysis of the contexts in which metaphorical statements are utilized" (Coffey & Atkinson, 1996, p. 86). This is particularly clear in the current research where the participants frequently use metaphors to define contextual and cultural differences between the two hospitals involved in the amalgamation. For example, one particularly potently expressed metaphor in the research

interviews held that amalgamating these two hospitals was the same as “bringing together the West Coast Eagles with the Dandenong Thirds” (the Interviews). The assumption here is that the interviewer and interviewee share, at the very least, a culturally grounded understanding that these terms apply to two football teams, and that one is perceived as being infinitely superior to the other. In fact, both actually and metaphorically, they are teams in totally different leagues.

Sarbin (1986) examined a special case of metaphor, that he calls “root metaphor”, a common achievement of human beings. That is, once the metaphor is expressed by the speaker and decoded by the listener, actions and properties related to the chosen metaphor serve as the source of auxiliary and supporting metaphors. For example, to identify a political figure as a puppet, leads to the use of related metaphors such as “pulling strings”, “manipulating characters”, “scriptwriting”, and so forth. In the current research for instance, several interviewees spoke about the new “network” structure of hospitals. Building on this image they then made other statements about “the creation of links between institutions and mechanisms”; “consolidation and a larger critical mass which allows you to do things better”, and so on (the Interviews). Once the metaphor has done its job of sense making, the metaphoric quality tends to become submerged. Sarbin (1986) said that unless we are constantly reminded of the *as if* quality of the expression, users of the term may treat the figure as a literal expression. “The once tentative poetic expression may then become reified, literalized”, and provide “the foundation for belief systems that guide action” (p. 5).

Limitations of Narrative

Clandinin and Connelly (2000) directed our attention to persistent concerns in narrative inquiry that “are first encountered as inquirers make preparations to enter an inquiry field” (p. 169), and included issues such as ethics, anonymity (of both participants and researchers), ownership and relational responsibilities, how we are storied as researchers, the distinction between fact and fiction, and possible risks, dangers, and abuses such as narcissism and solipsism.

One way of thinking about ethics, for example, is to view it as a response to meeting the university ethical guidelines for human subjects. However, Clandinin and Connelly (2000) believed that researchers inevitably find themselves in grey areas where the legalisms of informed consent are concerned. But when narrative research is considered as “collaborative research which requires a close relationship akin to friendship” (p. 171), researchers are freed up to “consult [their] consciences about [their] responsibilities as narrative enquirers in a participatory relationship” (Clandinin & Connelly, 2000, p. 172). This participatory relationship demands that narrative researchers rely on their own ethical resources before entering the chosen research environment. As researchers, Clandinin & Connelly (2000) became aware, for instance, that they had not entered into a value-free neutral context when researching the Bay Street School. They were already in the midst of living their own research stories, and they had been exposed to a web of stories from other researchers which led them to the school where they conducted their research, and set a context for the negotiations of the research relationship. They had an overall research agenda which resonated with the stories they had already heard about the school.

Clandinin and Connelly (2000) suggested that narrative inquiry can be supported with ongoing reflection, which they called “wakefulness”. For example, as we narrate the ethics of an inquiry, we need to be awake to the ethics that emerge from our narratives of experience as researchers. “The events in our lives, places we have been and the people we have known, keep coming back” (p. 172). As well, we need to be alert to ethical issues which affect the institution as a whole, “the grand narrative” in which participants are seen as subjects in need of protection in research undertakings. Persistent ethical issues and responsibilities emerge as the research unfolds, for example, confidentiality, anonymity and the burden of being witness to events that are being retold. Anonymity was a particular concern throughout the initial stages of this inquiry, and care has been taken to use pseudonyms for institutions and the research participants. A very recent conversation with a key person connected to this story indicated, however, that events had moved on, the amalgamation was part of history, and the original concern had dissipated. The researcher, remaining ever cautious, has continued to take care. We need to be wakeful to the possibility that the landscape and the persons with whom we are engaging as participants may be shifting and changing. “What once seemed settled and fixed is once again a shifting ground” (p. 175). However, researchers also owe care and responsibility “to a larger audience, to the conversation of a scholarly discourse” (p. 174).

As narrative researchers, we deliberately choose a language of wakefulness over a language of criticism. This quality allows us to set a narrative inquiry working ground by which we can proceed forward with “a constant alert awareness of risks, of narcissism, of solipsism, and of simplistic plots [the Hollywood plot, where everything works out well in the end],

scenarios, and undimensional characters” (Clandinin and Connelly, 2000, p. 182). However, we are also aware that narrative relies on criteria other than validity, reliability, and generalizability. “It is important not to squeeze the language of narrative criteria into a language created for other forms of research” (Clandinin & Connelly, 2000, p. 184). The language and criteria for the conduct of narrative inquiry, it should be noted, continue to be developed in the research community.

Most narrative inquirers “bump” into the question of who owns stories. This question is usually framed quite directly in terms of whether the characters named in the inquirer’s story own the story, or whether the inquirer owns it. Once again Clandinin and Connelly (2000) meet this challenge by reframing this concern about ownership into a concern about relational responsibility. “Questions of ownership are not as important as are questions of responsibilities to those with whom we are in relation” (p. 177). If this principle is followed, as trust develops between researchers and participants, researchers may indeed find themselves being more cautious about how participants are represented than are the participants themselves.

As well, the stories of who we are as researchers are evident in our field texts as we engage in interviews and conversations. The ways that participants talk with us tells us something about how we are storied, for example, as experts initially, and as trusted friends and colleagues as the participants come to trust our working relationship. The stories of who we are as researchers are also evident as we compose our research texts. Researchers need to be sensitive to the stories about who they, themselves, are (Clandinin & Connelly, 2000).

Another persistent issue in narrative research is the possibility raised by Clandinin and Connelly (2000) of a “muddled” distinction between fact and fiction. When pressed, what has seemed like fact can appear more and more as memory reconstruction, either the researchers or the participants. “Are these reconstructions best thought of as fact or fiction?” Drummond (1996) examined how the researcher needs to make judgements about truth (fact) in the narrative tradition by comparing the process with judicial reasoning. The type of reasoning on which a judge will make a decision with regard to a crime, comes to grips with the different way of defeating a claim or accusation. The verdict, in the case of a crime, is based on which interpretation appears to fit the facts or circumstances in the best possible way. There may be many interpretations of the circumstances, but a verdict “beyond reasonable doubt” allows the possibility that another interpretation could be valid. However, given the evidence available at the time, the verdict is the best that could be made. Polkinghorne (1988) supported this position. Human science can no longer only seek mathematical and logical certainty. Instead, it should aim at producing results that are believable and verisimilar. Truth in narrative research “uses the ideal of a scholarly consensus as a test of verisimilitude rather than a test of logical or mathematical validity” (Polkinghorne, 1988, p. 176).

In the case of the current research, the participants were invited to share their own experiences, to narrate their personal “story” about working within a health care environment which had been subjected to vigorous organizational change.

Wiltshire (1995), however, would have us maintain a distinction between story and narrative in the context of health care, on the grounds that “the former is an informal

activity, the latter is meditative and theoretical” (p. 75). Wiltshire’s (1995) viewpoint is not generally supported. Other health researchers such as Hunter (1991) and Toomb (1992), both cited in Wiltshire (1995), find no problem in using the terms “story” and “narrative” synonymously and interchangeably.

The researcher here does likewise. Further, it is interesting to note that while many of her interviewees were “hard-nosed” men and women of science who had been trained in the positivist tradition, there was no questioning, or criticism, of the methodology employed by the researcher. On the contrary, it would appear, at least where their own working experiences were concerned, that the interviewees showed no hesitation, and appreciated an approach which allowed for these experiences to emerge as their own coherent account, or story.

Finally, it is possible to support the use of a narrative methodology for its own sake in the current research, because narrative is an authentic way of understanding experience. Experience is the driving force in the choice of research methodology. We come to narrative inquiry as a way to study experience. Narrative is the closest we can come to experience. Narrative inquiry is an experience of the experience. Our guiding principle in our own inquiry is to focus on experience and follow where it leads. The particular focus of our research is to understand the experiences of a group of people in a community foreign to the researcher, who are responding to a set of events. Narrative inquiry gives the researcher within this context a point of reference, a ground to stand on for imagining what that experience was like, and how it might be studied and represented in text. Experience is the stories these people live.

People live stories, and in the telling of these stories, reaffirm them, modify them, and create new ones. What emerges is a win, win situation in which stories lived and told educate the self and others, such as the researcher, who comes into the community. The researcher cannot be divorced from the story because of their experience in space and time with the participants. This relationship also becomes part of the story. As such, there is little use for mathematical certainty or the application of tests and measuring instruments in such research. Ultimately, the position taken by this researcher is that narrative research as an activity remains well grounded and supportable.

CHAPTER FIVE

RESEARCH METHODOLOGY

Case Study

“Case study research excels at bringing us to an understanding of a complex issue or object and can extend experience or add strength to what is already known through previous research” (Soy, 1997, p. 1). Conversely, Stake (2000) informs us that “a case may be simple or complex” (p. 436). In any event, case studies can be seen to emphasize detailed contextual analysis of a limited number of events, or conditions, and their relationships. Researchers have used this research method for many years over a variety of disciplines. Social scientists, in particular, have made wide use of this qualitative research method to examine contemporary real-life situations, and provide the basis for the application of ideas and extension of methods. Case study satisfies the three tenets of the qualitative method: describing, understanding, and explaining (Tellis, 1997, p. 3). Yin (1989) defined the case study research method as an empirical inquiry “that investigates a contemporary phenomenon within its real-life context when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used” (p. 23). The goal of the case study method is to describe as accurately as possible the fullest, most complete description of the case (Zucker, 2001).

What can a well designed case study do? A case study can explain the reasons for a problem, the background of a situation, what happened and why. It can illustrate the complexities of a situation and all the factors contributing to it. It can explain why an innovation worked or failed to work by obtaining information from a wide variety of sources. It can show the influence of personalities on the issue under examination. It allows discussion and evaluation of viable alternatives. It presents information from a wide variety of sources which can cover many years, and describe how events in preceding decades have led to the situation under examination. For example, it can show the influence of the passage of time on the issue, through changes which have occurred in government policy and funding. It can spell out differences of opinion on the issue, from the viewpoints of different groups, and suggest how these differences have influenced the result. The case study is a search for explanation and theory rather than just a report of empirical research. The research material which emerges can be evaluated and summarized so that the conclusions which are reached and the knowledge which is gained ensures its potential applicability, both for the present and for the future (Merriam, 1998). These are likewise the goals of the present inquiry.

Attempts to define case study often centre on delineating what is unique about the research design. There are several unique features of case study research. Case study knowledge “resonates with our own experience because it is more vivid, concrete, and sensory than abstract [moreover] it is more contextual. Our experiences are rooted in context, as is knowledge in case studies. This knowledge is distinguishable from the abstract, formal knowledge derived from other research designs” (Merriam, 1998, p. 7). In general, case studies are the preferred strategy when “how” or “why” questions are being posed (Soy,

1997), and where the investigator has little control over events, such as in the current enquiry where we are attempting to understand a complex world of lived experience, from the point of view of those who lived it. The broad aim of the current study is to achieve a better understanding of how and why people within an organization have been affected by an event, an amalgamation of two hospitals. A case study has been selected as an appropriate choice for obtaining research data in this enterprise.

In the single case study presented, the researcher's aim has been to examine a specific instance or event (a hospital amalgamation), with a view to providing insights into a particular phenomenon which has hitherto had little local attention (the symptoms experienced by the survivors of this organizational change). Due to the holistic nature of the inquiry and the research techniques involved (interview and observation), the researcher had to become involved in a collaborative interchange with the interviewees, who were encouraged to talk freely with the researcher. The data which emerged from this mutual collaboration may or may not have been influenced by the researcher's admitted bias, but was viewed as contributing to the researcher's quest for understanding and analysis. Analysis of the data was intended to lead to interpretation and new knowledge. The interpretive inquirer, (the researcher) watched, listened, asked, recorded, and examined, and was directly involved in creating knowledge that was specific in time and place. The data which emerged was not forced to conform with any existing theory. Rather, interpretive categories were grounded in the data itself. The methodology of choice can be summarized as a case study which is single, revelatory, particularistic, descriptive, and heuristic. A description of these terms follows, starting with the concept of "single".

The case study presented in this inquiry is differentiated from other types of qualitative research in that it is an intensive description and analysis of a *single* unit or bounded system (an event). Merriam (1998) concluded that “the single most defining characteristic of case study research lies in delimiting the object of study, the case” (p. 4). She referred to Smith’s (1978) notion of the case as a bounded system. This comes closest to Merriam’s understanding of what defines this type of research, as does Stake’s (2000) definition of the case as an “integrated system”. Both Smith’s and Stake’s definitions allowed Merriam to present the case as a thing, a single entity, a unit around which there are boundaries. We can thus “fence in” what will be studied. If the phenomenon we are interested in studying is not intrinsically bounded, it is not a case. If there is no end, actually or theoretically, to the number of people who can be interviewed or to observations that can be conducted, then the phenomenon is not bounded enough to qualify as a case. In the current research, the investigation of the experiences of a specific group of interviewees, was limited to a single situation (an amalgamation). As such, it qualified within Merriam’s (1998) definition of a case.

Another way of describing the case study is to highlight its *revelatory* properties. When an investigator has the opportunity to uncover some prevalent phenomenon previously inaccessible to scientists, such conditions justify the use of a single-case study. Merriam (1998) referred to the work of Guba and Lincoln (1981) who see the purpose of the qualitative case study as “reveal[ing] the properties of the class to which the instance being studied belongs”(p. 5). Merriam sees this view as congruent with MacDonald and Walker’s (1977) definition of a case study as “the examination of an instance in action”(p. 5). As well, Merriam (1998) cites Becker (1968), who defined one purpose of the case

study as “to arrive at a comprehensive understanding of the groups under study” (Merriam, 1998, p. 5). It is possible to view the current inquiry in terms of its revelatory nature on the grounds that, with the notable exception of some studies conducted by Craig Littler and his colleagues (for example, Littler, Bramble & McDonald, 1994; Dawkins, Littler, Valenzuela & Jensen, 1999; Dawkins & Littler, 2001), very little research has been conducted previously into survivor syndrome in the health sector within the Australian context.

As well, qualitative case studies can be characterized as being *particularistic*. This feature refers to the focus of the case study on a particular situation, event, or phenomenon, for example, an amalgamation. The case itself is important for what it reveals about the phenomenon and for what it might represent. This specificity of focus makes it an especially good design for practical problems; for questions, situations, or puzzling occurrences arising from everyday practice. Case studies concentrate attention on the way particular groups of people confront specific problems, taking a holistic view of the situation. Shaw (1978, cited in Merriam, 1998) viewed them as “problem centered, small scale, entrepreneurial endeavours” (p. 6). Here it is important to note Stake’s concern that “the search for particularity competes with the search for generalizability” (cited in Denzin & Lincoln, 2000, p. 439). While each case has important atypical features, happenings, relationships, and situations, pursuit of understanding of these atypicalities not only robs time from the study of the generalizable, but also diminishes the value, to some extent, that we place on demographic and policy issues.

Descriptive is yet another feature of case study. This means that the end product of a case study is a rich “thick” description of the phenomenon under study. Geertz (1983, cited in

Herda, 1999) believes that “true understanding can be attained through thick description” (p. 81). Thick description is a term from anthropology and means the complete, literal description of the incident or entity being investigated. Case studies can also be longitudinal, as in the current research. They are also able to be labelled holistic, lifelike, grounded, and exploratory. The description is usually qualitative, that is, instead of reporting findings in numerical data, “case studies use prose and literary techniques to describe, elicit images, and analyze situations [and] they present documentation of events, quotes, samples and artifacts” (Merriam, 1998, p. 6). The current study, where the aim has been to gain a close-up detailed rendition (thick description) of a real situation, fits Merriam’s description.

One further feature of the case study is its *heuristic* quality. This means that case studies illuminate the reader’s understanding of the phenomenon under study. They can bring about the discovery of new meaning, extend the reader’s experience, or confirm what is known. As Stake (1981, cited in Merriam, 1998) noted, “previously unknown relationships and variables can be expected to emerge from case studies leading to a rethinking [reinterpretation] of the phenomenon being studied. Insights into how things get to be the way they are can be expected to result from case studies” (p. 6). In the current research, direct observation and systematic interviewing were the techniques employed to yield major themes that could contribute to our theoretical understanding. Specifically, the case examined in the study was directed to learning about the interplay between people, government policy and organization within the setting in which this interaction occurred.

In actual research practice, cases are chosen for all sorts of reasons, from convenience and familiarity, to fascination and strategy. Once chosen, however, the case must be justified - shown to be a case of something important. “A case study design is employed to gain an in-depth understanding of the situation and meaning for those involved” (Merriam, 1998, p. 2). Frequently the new case is justified by showing not only that it pertains to the interpretive issues generated in similar cases, but also that it adds something to substantiate or, preferably, expand earlier understandings. In this context cases are often chosen because they are potential examples of the research topic. Thus, the current case study was chosen because it offered an opportunity to learn something from the process; firstly, something that might extend our understanding of change management practices, and secondly, of survivor syndrome, in the context in which it was examined. A second form of case justification is analytical in that a strategic argument is developed for the case. The data which is yielded from the case study can contradict or reveal previously unseen inadequacies in the theoretical notions guiding the research, providing a basis for reassessment or rejection; the data can confirm the theory; the data can also force us to create new hypotheses, adding detail to the theory, model, or concept, “more fully specifying it” (Vaughn, 1992, p. 175). In the present research, the data can be seen to confirm the presence of survivor symptoms in the participants while adding detail about how these symptoms present within a hospital environment.

In the long run the terms “case” and “study” defy full specification. A case study is both a process of inquiry about the case and the product of that inquiry (Stake, 2000). Merriam (1998) also identified the confusion surrounding case studies. The process of conducting a case study is conflated with both the unit of study (the case) and the product of this type of

investigation. Merriam (1998) herself defined a qualitative case study in terms of its end product: “an intensive, holistic description and analysis of a single instance, phenomenon, or social unit” (1998, p. 4). Arguably, it is most useful to think of a case as a bounded system: a specific, unique, bounded system. It is usual to recognize that certain features are within the boundaries of the case, and other features outside, but both are facets of the case. Boundedness and behaviour patterns are useful concepts for specifying the case. The case study presented in the current research is a concentrated inquiry into a single case which is representative of the Victorian hospital system at the time of the investigation. The purpose of the specific inquiry is to achieve a better understanding of the interplay between the people in the hospitals which lie within the hospital system, and the events which played out over time in the way they did. Within the boundaries of the two hospitals chosen to represent the hospital system, is a group of people who we can expect to be responding, either functionally or dysfunctionally, to a particular event, specifically, an amalgamation of the two hospitals. The reactions of the people who are being investigated are unique and specific to this event (within the boundaries), but are also reactions to the dynamics operating within the system in which the amalgamation has occurred (outside the boundaries of the specific event). Nevertheless, while government health policy, both within the Federal and State arenas fall into the area outside our bounded system, as do ideas and strategies concerning change management and survivor syndrome, they are still integral to the case and are thus covered within the investigation.

A potential vulnerability of the single-case design is that a case may later turn out to be not the case it was thought to be at the outset (Yin, 1989). Single-case designs therefore require careful investigation to avoid misrepresentation and to maximize the investigator’s

access to the evidence. Zucker (2001) drew our attention to the work of Stake (1995) who emphasized that the number and type of case study depend on the purpose of the inquiry. For example, he differentiated between an “instrumental” case study which is used to provide insight into an issue; an “intrinsic” case study which is undertaken to gain a deeper understanding of the case; and a “collective” case study referring to the study of a number of cases in order to inquire into a particular phenomenon. Whilst Stake (1995) recognized that many other types of case study existed, depending on their specific purpose (for example, the teaching case study; the biography), he emphasized that irrespective of the purpose, unit of analysis, or design, rigor is a central concern. Feifin, Orum, and Sjoberg (1991) suggested that while proponents of multiple case studies may argue for replication, “using more than one case may dilute the importance and meaning of the single case” (Zucker, 2001, p. 1).

With respect to analysis of the case research material, Zucker (2001) contended that the generalization of case study findings is limited to the case itself. “Theoretical generalization is to the domain of case study, what statistical generalization is to the true experiment” (Zucker, 2001, p. 5). Yin’s (1989) response to the frequently asked question, “how can you generalize from a single case?” is to point out that “case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes (p. 21). In this sense, the case study, like the experiment, does not represent a “sample”, and the investigator’s goal is to expand and generalize theories (analytic generalization) and not to enumerate frequencies (statistical generalization). He argued nevertheless, that attention to selected details enhances the analysis and increases clarity of reasoning. Stake (1978, cited in Lincoln & Guba, 2000) focused on content-specific or

“naturalistic” generalization. Stake’s (1978, cited in Lincoln & Guba, 2000) kind of generalization is “more intuitive, empirical, based on personal direct and vicarious experience - that is the meaning intended by the term naturalistic generalization” (p. 36). Such an approach resonates with readers’ tacit knowledge, which helps people make connections and associations without the benefit of words. It is believed that people have the capacity for this kind of knowledge, and from it they build understandings. Lincoln and Guba (2000) preferred to replace the classic idea of generalization, not with naturalistic generalization but with a new formulation proposed by Cronbach (1975, cited in Lincoln & Guba, 2000) who contended that “when we give proper weight to local conditions, any generalization is a working hypothesis, not a conclusion” (p. 39). In her own study in the area of nursing research, Zucker’s (2001) approach (as in the present inquiry) was to identify major themes which then emerged as focal areas of analysis. The metaphor “journey” became Cronbach’s central organizing concept, and is linked to a variety of subconcepts, and relationships among them are sought.

Yin (1994) outlined a strategy that encouraged researchers to make every effort to produce an analysis of the highest quality. That is, the researcher must show that the analysis relies on all the relevant evidence. All major rival interpretations must also be included in the analysis, which must also be directed toward the most significant aspect of the case study. In addition, according to Tellis (1997) the researcher’s prior, expert knowledge can be used to further the analysis.

In case study research internal and external validity, which are the constructs of a positivist paradigm, are replaced by constructivist paradigm terms such as “trustworthiness” and

“authenticity”. Zucker (2001) noted that in general terms, qualitative investigations from many disciplines have come to rely on the trustworthiness criteria as described by Lincoln and Guba (1985), which included features such as credibility, applicability, dependability, and confirmability. These qualities are constructed to parallel the conventional criteria of inquiry of internal and external validity, reliability and neutrality, respectively.

To sum up, in this research a single case study is presented to explore the phenomenon of change management as a component of organizational change. Specific attention was given to the amalgamation of two neighbouring hospitals who had hitherto enjoyed an independent status. The study focused on the responses of staff attempting to come to terms with the new hospital structure, and the effect on their conditions of employment of this large-scale organizational change. In this exploration the researcher’s intention was to investigate and capture an appreciation, over time, of the living world of a group of people responding to organizational change. To facilitate this understanding, an epistemological stance of immersion over a period of time was considered to be an appropriate strategy.

The methodological emphasis in the research was to bring forward into narrative coherence through research conversations or interviews, the subjective experiences of two small groups of hospital employees who were participants in the amalgamation. It was expected that the amalgamation would be experienced traumatically for the participants as they attempted to adjust to loss of colleagues, as well as to decreased levels of job security and job morale. The methodology chosen was suitable for the present inquiry because it encompasses a way of thinking about, and conceptualizing data, which is easily adapted to studies of diverse phenomena. The methodology allows data about human behaviour to be

approached in the form of descriptions and meanings, rather than analyzed as simple causal, deterministic mechanisms. The strategy is supported by Hiles (1999) who sees this approach as determined by the perspective that human behaviour is complex and that “humans respond not to events, but to the *meaning* of events” (p. 3). Human behaviour and experience are viewed as the consequence of multi-determined factors. “We are historically, culturally and socially imbedded” (p. 3).

The researcher was cognizant of the need to maintain appropriate ethical standards and behaviours, recognizing that there is no “right to know” (Ryan & Bernard, 2000, p.447) per se, and that permission to interview some-one “does not constitute licence to invade the privacy of others” (Ryan & Bernard, 2000, p.447). It should be noted also that the study was begun prior to the University having developed its ethics application form to enable research to be officially sanctioned before work has begun. Thus, the researcher arranged for herself and the Director of Operations to meet and discuss the research. A full and frank discussion was held in which it was explained that interviews were being sought to talk to staff, who volunteered to be interviewed, about the changes occurring in the health system, and how these changes were impacting on their work. Assurances were made that the research would only be published as a PhD thesis to be held in the Swinburne library, and possibly in a scholarly journal or conference, and would not be used in any other way. It was agreed that interviews would be scheduled so as not to interfere with paid work-time, and that pseudonyms would be used in place of the individuals’ names and the original names of the hospitals, including the new amalgamated entity. There was an initial thought to use job titles rather than real names for the participants but even this was considered to be too risky and in the end it was decided it would be best not to identify individuals at all.

A further contributing factor to this decision was the highly political nature of the amalgamation. A letter of confirmation of these agreements was drawn up and signed by all. Need for confidentiality precludes the inclusion of this letter as an appendix to this thesis.

The Participants

The researcher's initial contact with several potential participants was greatly facilitated by her already established contact within one of the hospitals involved in the amalgamation. Twelve people were finally approached (often as a result of the direct recommendation of an earlier interviewee) and invited to participate. There were no refusals. Participants were composed of six people from each of the former campuses of the now amalgamated hospital. Initial interviews were conducted over a time frame from July, 1995 to January, 1997. A follow-up interview was conducted with each interviewee. These interviews occurred within an interval from November, 1998 to July, 1999. The second interviews were more structured and relatively short. In one case, the follow-up interview had to be conducted by telephone as the participant had relocated to another State. On several occasions the researcher went back to one or two respondents for additional information or assistance with her understanding of events. As well, the researcher was able to access hospital records, annual reports, and the written histories of the hospitals. These were located in the Delta Medical Centre library, or with people such as the former Medical Superintendent of the Alpha Hospital and a former Chairman of the Board of the same hospital.

The participants came from several clinical specialities, such as cardiology, and general medicine, from allied health areas such as physiotherapy and dietetics, from nursing, from members of the Board of the hospital, and from medical administration. At the time of the initial interviews they had all held senior roles involving responsibility in the former hospitals, and continued to do so in the Delta Medical Centre.

All these individuals, except for one administrative officer, were tertiary qualified and held post-graduate qualifications in a variety of professional capacities including general medicine, cardiology, nursing, physiotherapy, dietetics, hospital and business administration, organization planning, and so forth. Many had dual qualifications in their branch of medical or allied health practice, as well as holding post-graduate business and administration qualifications. The administrative officer had worked his way up through the ranks. Five females and seven males were included in the sample.

Collecting the Data

Conducting research interviews (research conversations) was the predominant method used for collecting data in the inquiry. The researcher's rationale comes from Mishler (1986) (discussed earlier) who classified interviews as primarily linguistic occurrences, at the heart of which is the proposition that they are a form of discourse shaped and organized by asking and answering questions, and from Herda (1999) who believed that a narrative interview can also be thought of as a research conversation where the conversation "is a process of two people understanding each other" (p. 123). From Herda's perspective, each person participating in the conversation needs to be open to the other, and truly accepting

of the other's point of view. Each needs to "hear" what is said by the other, as opposed to understanding the other person saying it. Mishler's (1986) interpretation of "interviews" and Herda's (1999) concept of "research conversations" are similar in their emphasis on interviews as places where joint constructions of meaning are developed. The participants in the current research were approached by the researcher with this understanding of research interviews in mind.

The researcher approached each participant conscious that she needed to establish conditions that would facilitate meaningful talk to occur, including interviewees having a sense of being "listened to" within an environment of mutual trust and respect. A contact was made initially with each interviewee by telephone. A brief explanation was made regarding the research, and an initial interview was requested and organized, in a place, and at a time, of the interviewees' own choosing. The researcher informed each contact about the conditions laid down by the Medical Centre. Some interviews were conducted in the interviewee's place of work, usually over an extremely extended lunch break, while other interviewees preferred to see the researcher after hours and at home.

The initial interview saw the researcher explaining the purpose of her research before proceeding with the narrative interview. Confidentiality was assured in each case. Pseudonyms are used throughout the research text to preserve interviewee anonymity. Each interviewee was encouraged to speak freely, and each was assured that no part of their interview would be revealed to any other interviewee.

After noting each interviewee's qualifications and current employment status, the researcher began the narrative interview broadly, by asking the interviewee, "How do you feel about what is happening in the Victorian health system at this time?" This broad line of inquiry was established to enable interviewees to set down for themselves the experiences they were personally having, and to allow them to explore for themselves the meanings they were making from these experiences. Further questions were minimal and were generally asked when there was a need to seek clarification, or to enhance meaning. The researcher, at all times, conveyed her keen interest in the others (the interviewees') significant world. The researcher's aim mirrored Emden's (1998) description of working "to construct an animating, evocative description of human actions, behaviours, intentions, and experiences" (p. 30), as is met in the real world. The interviewees were extraordinarily generous in their sharing of experiences that, for some, re-awakened feelings of anger, frustration, guilt, and grieving as they re-lived the experience of the amalgamation and its accompanying events. There was no objection on the part of the interviewees to the researcher making a further contact at a future date.

The data from the initial interviews was sorted into two groups according to the hospital of origin of each of the interviewees. Accordingly, the material from six interviews in each case has been analyzed and arranged thematically as a series of shared perceptions which emerged from the interview data. In the manner of schema analysts, the researcher looked "for metaphors, for repetitions of words, and for shifts in content" Agar and Hobbs (1985, cited in Ryan & Bernard, 2000, p. 780). That is, the tape-recorded interview data was transcribed and different themes identified from the words expressed by participants. Each theme was colour coded on the transcripts to facilitate quick identification, and all

comments by participants that related to the same theme were collated. As mentioned above, the material was arranged thematically as a series of shared perceptions (see Chapter Six) to minimize the risk of participants being identified.

The content which has been included in this thesis under each perception, or theme, is expressed in the language of the interview-participants. The researcher's aim in this is to enable the participants to tell their own story, in their own words, over real time, as these stories occurred in real life. In the following chapter the story of each group of participants will be told thematically and sequentially. Within these themes there will be included any dissenting voices, or conflicts of opinion, as these were expressed by the interviewees. Perceptions that reflect similarities or differences between the two groups of interviewees will be compared. Material from the follow-up interviews will also be reviewed.

CHAPTER SIX

PRESENTATION OF THE NARRATIVES

Introduction to the Narrative

The material in this section has been taken from the original interview transcripts and arranged thematically as a series of chronologically-ordered perceptions for each group of interviewees who participated in the research. In this study the researcher's aim was to present the voices of those involved with the amalgamation of the Alpha and Beta Hospitals, as they became the Delta Medical Centre. Interviewees have been encouraged to express their opinions and share their experiences in their own voices. In line with narrative methodology, the researcher has been involved through actively constructing meaning and engaging in dialogue. Participants in the study have shared their stories with the researcher and the interviews have provided them with the opportunity to share their feelings. The stories are full of fine detail. The content is full of emotion. The researcher has documented the material which was generated, thereby gaining critical insights. The researcher is now retelling the story so that the voices of the participants are used together as one voice and their meaning is reconceptualized. This is the final representation of the researcher's consolidation of events. Later in the narrative re-telling the researcher has included information from the follow-up interviews which were conducted with the participants.

The Hospitals at the Centre of the Research

The current research is based on the experience of two existing hospitals in the early 1990s. In agreement with the hospitals concerned, these institutions, affiliated hospitals, and some geographical locations have been given fictitious names within the body of the research. A summary history of each hospital is presented before the narratives. The narratives are presented as themes. These themes have been derived from the words of the participants, which can also be seen as direct quotations within the text. These are deliberately not attributed to particular participants, in line with the undertaking given to them at the start of the research.

The Alpha Hospital

The Alpha Hospital was founded in 1882. Prior to amalgamation the annual report of the hospital (1993-1994) noted that it had 2,465 full time equivalent staff. It occupied 8.6 hectares on sloping land in a northern suburb. Its buildings could be described as tall, but congested. It served a catchment population of more than 500,000 people. As a major teaching hospital with 641 beds, it provided general medicine and surgery, cardiac, neurosurgical, spinal, renal, orthopaedic, rehabilitation and other specialized services for Victoria and other parts of Australia. In April 1988, the Alpha was amalgamated with the Gamma Hospital. A new state-of-the-art Spinal Rehabilitation Facility was later established on the Gamma site. The new facility was formally declared open in February, 1994. The vision for this state-of-the-art complex was to further enhance the Alpha's reputation as one of the world's leading spinal cord trauma and rehabilitation hospitals.

In the period immediately before amalgamation, the Alpha Hospital espoused as its primary mission the development and delivery of the highest quality, cost effective and accessible health care, to meet the needs of the community it served. Its stated vision was to lead the way in patient care, teaching and research, regionally, nationally and internationally. Its long text of philosophy expressed sentiments such as “most efficient” and “staff of the highest quality”. Included in its strategic directions were its ambitions to “achieve wide recognition”, with “defined areas of innovative excellence” and “highest standard”.

The prevailing image projected by the Alpha Hospital was of an ambitious, confident, efficient, innovative and achievement oriented organization. People at the Alpha were “the best”, “first class”, “passionate to the extent of being tough”, “idiosyncratic”. There was a strong sense of team spirit and commitment. As well, on staff, there were a number of people who were respected and feared. These strong personalities were not team players, but were nevertheless perceived as instrumental in the development of the hospital as a cutting-edge institution. The Alpha Hospital had a strong culture of medical dominance which implied a somewhat authoritarian and task-focused approach.

The Alpha Hospital was seen as a competitive, strong and aggressive institution. It was “brought up” in a tough and competitive world where individuals had to earn their own living. They had learned to strive, and this had shaped their ideology. People at the Alpha looked for external validation, for recognition from the outside world. They always had to prove their importance and value and justify their existence by high output, efficiency and international recognition. The hospital had experienced successes in the past. The hospital

had incorporated the Gamma Hospital in 1988 in an operation that had proceeded very smoothly. People at the Alpha were thus arrogant in the face of an impending amalgamation. They expected to achieve more growth and control. To them it was just another expansion of their empire.

The Alpha Hospital Interviews

Perception that the Alpha hospital had already experienced an earlier amalgamation but with better outcomes for staff well-being:

There have been, in fact, two amalgamations. The first amalgamation which occurred was between the Alpha Hospital and the Gamma Hospital. This amalgamation also had a big impact, but it had affected a smaller number of people within the larger organization because it involved a rehabilitation centre with few medical staff and a small number of nurses. It was really more the case that the Alpha Hospital “gobbled up” the Gamma Hospital, which for people at the Gamma Hospital was pretty horrendous. While some of the Gamma Hospital’s resources were stripped and relocated at the Alpha Hospital as a result of the amalgamation, the pay-off was that the Gamma Hospital was finally re-resourced with a new spinal rehabilitation unit, including a new state-of-the-art building. Finally, the Gamma people came around to seeing the merger as a good thing, but this took some years and a lot of developments.

This merger between the Alpha and the Gamma Hospitals was handled very well in that people were allowed to mourn for what they were losing. What was important was that people were allowed to grieve without comment. For example, there was a yearly review

where staff acted out their feelings through irony. Senior people from the Alpha went to the reviews and handled it well. They “maintained the humour”. In the first year following the amalgamation, the Gamma Hospital people shot off a cannon which was directed at the Alpha Hospital. Fifty percent of the skits in the second year post-amalgamation were about the amalgamation. By the third year post-amalgamation there were none. This was accepted as a sign of the good health of the unit.

Perception that some form of re-organization and rationalization was necessary in the health industry:

At the time of the amalgamation, the health industry was in need of a good shake-up. There was a sense that this could be best achieved through the rationalization of services to better meet community needs and, additionally, that it would result in “an elimination of the wasteful competition which currently pervades the system”. The health system as it existed had become too expensive, and there were inequalities in existence, such as the tendency to over-investigate certain patients. While the standard of medicine was high, financial accountability was a dimension that was missing in the health system as it stood at that time. The amalgamation was justifiable and realistic therefore when you considered the financial situation.

Perception that the amalgamation of the Alpha and Beta Hospitals was a positive move and that the setting up of a new network structure would be beneficial in the long term:

An exciting prospect was the future potential which could be achieved through amalgamation and the consolidation of the hospitals. For example, this meant the opening up of new opportunities to do things better as an outcome of the provision of a larger

critical mass. Moreover, the amalgamation of the two hospitals under consideration was supportable on the grounds of their geographical proximity. “It is simply the sensible thing to do”. As well, the regionalization of the amalgamated hospitals under a network structure was long overdue. The network structure would allow links between the the hospitals, while it would provide mechanisms to redistribute services from the inner city to outer Melbourne where the bulk of the people requiring the services were now living. The network structure would introduce the principle of a network Board. This was a positive concept and it meant that the hospitals in the network would be encouraged to operate holistically to provide the health care the community needed, rather than providing only what the doctors wanted to give. It was healthy for people such as hospital managers and the medical staff to examine what they had been doing, the costs, and what the future benefits of the network might be.

Perception that it was the management of the restructuring that was harmful:

It was “the process of amalgamation rather than the idea of it that was badly mismanaged”. This happened largely because the appropriate health care professionals were excluded from the process. Former members of the Alpha Hospital Board, who had put in a lot of time and effort to facilitate the change, were pretty well steam-rolled off the network Board. Instead, the management of the change was put into the hands of people “who have no understanding of the ethos of the Alpha Hospital and who have approached the task arrogantly”, so that the process was handled very insensitively, just at the time when there was an acute need for sensitivity and sensibility. Ineptitude was also part of the picture. The change management process lacked coordination in the form of a competent group of people who could assume responsibility from the outset. Instead, the management of the

amalgamation was controlled by people who instituted change in the form of a series of bad surprises. While people could handle bad news, they had difficulty digesting bad news in this form. Another issue was that, over time, the people who were affected by the amalgamation came to see it as being driven largely by financial considerations on the part of the Government. While initially there was some lip-service paid to quality of care considerations, this seems to have taken on a secondary role in the Government's attempts to maintain financial control over the hospital. As time went on, the emphasis came to be more and more on costs and less and less on benefits, while certain areas, which in the past had made the Alpha Hospital outstanding, such as research and teaching, began to suffer. While most people who were affected by the amalgamation could accept the need for change, they had difficulty accepting the two events which happened simultaneously: That is, the changes within the public hospital system (for example, budget cuts and case mix), as well as the amalgamation of the hospitals. "Both things were too much for people". People, including the consumers, did not feel particularly happy about these changes. They felt disturbed about the overall change, the direction of the change, and the rate of the change.

Perception that the process of change was determined politically:

"Politics as well as economics has had a lot to do with the way the amalgamation of the two hospitals was managed". Amalgamation was not a new concept for the hospitals involved. Most of the hospitals had already planned for them in an informal process, but the hospitals no longer had any substantial control over the process. The amalgamation was economically motivated but the process was politically driven by the Health Department which took very direct action. "It was a bigger merger than one of the Alpha and the Beta.

It was a merger between the Department and the Beta and the Alpha”. As well, there was the possibility of a preference being shown for the Beta Hospital in the matter of appointing department heads. While it is hard to point to any suggestion of payback in this situation, it appears as if the influence of the Alpha Hospital was marginalized at the management level, within the newly amalgamated medical centre.

Perception that the political process driving the amalgamation was handled ineptly:

A Planning Board was appointed to oversee the process of bringing the hospitals towards amalgamation. The people who were appointed to make the project happen adopted a clinical boring approach which was totally unimaginative. Meetings stretched over eighteen months and could be summed up as debilitating and inefficient. The President of the Board of the Alpha hospital tried very hard, but found it difficult to go to the Planning Committee meetings and hear about silly decisions being made. “She (the Minister) said one thing and did another. No one really said what they thought or told the truth”. For one member of the Committee in particular, the amalgamation was a big step in her career prospects. She made mistakes because she was utterly focused in that direction, and she was not interested in consulting.

Perception that there was an anti-Alpha Hospital sentiment in the amalgamation process:

In the atmosphere that surrounded the process of amalgamation there was a sense that “the Alpha Hospital was being done to; that it was no longer in control of its own destiny”. The Alpha Hospital had already experienced a bad relationship with the Government before the amalgamation. It is possible, on the one hand, that the Government had decided to make an example of the Alpha Hospital, and in so doing send a signal to hospitals in general that

things were going to change, and that they couldn't use past methods. Part of what might have been driving the agenda was "to teach the Alpha Hospital and its Board that things were not going to go their way". As things were, certain people in the Health Department were resentful of the Alpha Hospital because the hospital had stood up to people in the Department. Some people in the Health Department thought that the Alpha Hospital was just "too big for its boots". There was no question that at the time of the amalgamation, the Alpha Hospital had the greater reputation of the two hospitals, so it was expected that it would be the senior partner in any amalgamation. But the Department chose itself to be the leader, "the superior party". At the same time there appeared to be deals done, and when the initial Board of the amalgamated medical centre was formed it seemed to have a strong bias toward people on the Beta Hospital Board.

Perception that the Alpha Hospital site was a preferred site choice for building the new Delta Medical Centre:

When it came to the question of a choice of site for the new medical centre, "it was unthinkable that the Beta Hospital site would be chosen". There were powerful arguments for locating the re-development at the Alpha Hospital site. Geography was one such powerful consideration. What needed to be considered here were factors such as the close proximity of the local private hospital, the current location and ownership of the private rooms of the medical staff, and the strong feelings of history and ownership invested in the Alpha Hospital site by the local community, and by its client base. However, these were not the only people who would be affected by a negative outcome. A further consideration was the commitment already made to the Alpha Hospital by outside institutions such as the University, which already had a presence on the site in the form of buildings and

infrastructure dedicated for teaching and research. The University was very upset about the situation. “It indicated that it would not be party to providing funds for any re-location”. There could be no suggestion of selling off the sites of both hospitals and starting somewhere else. Financially, it just made good sense to choose the Alpha hospital as the preferred site, “especially if you didn’t have a bucket of money”.

Perception that as a result of the amalgamation people were put into powerful positions who were neither competent nor appropriate:

There were a whole lot of problems associated with critical figures who ushered in the amalgamation and the new network leadership. Both the old leadership of the Alpha Hospital and the new CEO of the Delta Medical Centre were seen as problematic. The old leadership was perceived as “too considered”. He wasn’t strong enough so he simply side-stepped any confrontations with the bureaucracy. He accepted that there was nothing he could do to alter the process, so he just rolled over with the punches directed at the hospital. He had all the stuffing knocked out of him. He was never going to survive in any case because he could never present as a visionary. “He just came over as tired, lethargic, parochial”. Conversely, while the new leadership of the amalgamated hospitals was intellectually OK, he had his own set of problems. He had no people skills. “He has trouble handling human resources”. He seemed very insecure, probably because he had never been a CEO before. He was not coping too well but he didn’t want to be shown up as such, so he surrounded himself with wimps. When other people did important work, this wasn’t attributed to them but to this CEO. Finally, the Chairman of the new network Board was perceived as very arrogant and dull. He was politically well connected, “but he is not very smart although he doesn’t seem to have realized this”.

Perception that there were winners and losers in the process of change and that some very good senior people were very badly hurt in the amalgamation process:

“Individuals have gone from being centrally involved to being on the outer and this has involved a loss of status and power”. In any event, it led to the frustration felt by former Department heads who no longer had the autonomy to perform their jobs. They had enjoyed heaps of autonomy before. These good senior people who believed that they had something to contribute experienced disempowerment, because the process of change was handled badly. What they felt was not just ordinary disempowerment but also disempowerment borne of the knowledge that they could have done things better. “It was also the case that under the prevailing conditions, certain people have promoted their own causes”. A further scenario occurred when you had two former Department heads and one had to go because of the restructuring. If one of them didn’t take a package (or couldn’t take a package), circumstances meant that one of them had to be subordinate. This was the case with one employee. She was told blatantly that her contract was not to be renewed. In general, this set of circumstances led to a tremendous lowering of morale amongst the people who knew that they had lost out in the restructure. There was a perception of “B” team people winning the race at the senior executive level. This situation could also be described as akin to “the dissolution of the monasteries”. Of all seven senior appointments that were made in the new medical centre, three went to Beta Hospital people and all others to outsiders. No Alpha Hospital people were appointed to senior executive positions in the amalgamated structure.

Perception that there were two distinct and disparate cultures at the Alpha and Beta Hospitals:

The Alpha: While both hospitals were good each had its own strengths and weaknesses. In some ways this could be viewed as complementary. Nevertheless there were clearly differences in the characters of the two institutions. The Alpha Hospital was an organization which “worked hard and promoted heroes”. It was “a passionate organization”, a “risk-taking organization” which took a great pride in itself. This meant that while it cared for people, it was primarily task-focused. It was a place where you could always have your say. It cared that you were developed as a professional. There was an enthusiasm for allowing people to give things a go within reasonable boundaries. There were high expectations of the workers and an environment where excellence was encouraged. The Alpha Hospital was a place with a strong identity but with no corporate image. Nevertheless there was a tremendous camaraderie. You could say that overall, educationally the Alpha was the stronger hospital. Clinicians working on the two campuses tended to reinforce this opinion. This did not mean that there weren’t areas of relative weakness at the Alpha such as respiratory medicine, which was quite good at the Beta Hospital, but, in general, things were more likely to happen at the Alpha Hospital where the pace was faster.

The Beta: The environment of the Beta Hospital was different. It was “a family place which encourages team work but where there are no heroes”. Nice things were done there for people. “It is a nice environment ... friendly. It is people-focused”. People were proud of their ability to care for each other. They were keen to make sure that people felt happy and supported. It was an environment where it was seen as more important to get along

with other people than to be seen as an individual. It was a hospital where there was time to learn. It had a corporate image with symbols such as a hospital logo. It had a corporate quality program and it did a lot of wider organizational work. On the down side, the Beta was a less efficient place because of the nature of its funding, which was external and provided by the Commonwealth. There was a lack of financial accountability, for example a lot of people were being paid for higher duties when they weren't performing them, and this needed to be rationalized. Moreover, a lot of the staff there were part-timers with allegiances to other hospitals.

Perception that people were damaged in the amalgamation process and that they were showing symptoms:

In general, morale was pretty low and many people were showing a variety of symptoms which confirmed this. For some people, their past work was not being recognized. Their sick leave was increasing. Other people were stressed and they weren't sleeping or they were having nightmares about how hard and how horrible their experiences had been. People felt like "the organization is an open wound. It is a painful place to work". These people were seen as having lost their meaning. They presented a physical presence and they were not going to make a decision to leave, but at the same time they didn't really fit in any more and some of them should have been forced to go. "They had become spare floating bodies. It would have been kinder if they had gone". Their colleagues felt sorry for them. They had become dysfunctional. You didn't feel sorry for them before. As well, there was a feeling of anger. People were angry, resentful, and felt unappreciated. 'People are angry and pissed off. They feel devalued in the organization'. Some people were stuck where they were, and this was largely because the change had gone too fast and they hadn't

coped at all. “People are still grieving”. People’s attitudes seemed to depend on how long they had been there. Some stayed on because they had no choice, but they had become withdrawn and non-productive. Other people had become positively and actively destructive. People had a feeling of uncertainty as to their position within the organization and this produced stress. People weren’t given a lot of say in what was happening and the end result was a loss of loyalty to the organization, although the medical staff unquestionably still had a lot of loyalty to the patients.

Perception that very little was provided to help people through the process of amalgamation:

The general consensus was that what was offered was totally inadequate to meet people’s needs. There was an employee scheme that was set up to help employees who were going, but it consisted of only one, at the time of the interviews unfilled, counsellor position, that had only recently been advertised. There was a bit of counselling provided via the hospital psychiatric services but not much. There were no outplacement schemes for staff. Help for people was just starting but this added up to too little, too late. It included change management workshops, counselling, vocational counselling. Anyway, this was all somewhat academic as the medical staff wouldn’t go to change management workshops. “They are a maverick lot”.

Perception that the changes in the public health system were having a detrimental effect on patient care:

In terms of the specific things that were done to hospitals, such as the budget cuts, this was abominable. It was a matter of having to make choices about people getting appropriate

care and this added up to the difference between life and the quality of life. There was a pessimistic outlook for the future, and it was predictable that the end result would be that the quality of patient care would suffer as well. Patients were finding it harder to get a bed in a hospital. Moreover, they were given very little time to recover from major illnesses before they were discharged home, and then pressure was put on their families. An enormous amount of encouragement was being given for privatization as a result of the diminished funding and downsizing. There was encouragement for departments which could privatize, for example, cardiology, gastroenterology and cardiac surgery, while other departments who had equally important roles such as general medicine, general surgery and urology, were seen either as needing to earn their keep or, very likely, to face being reduced in numbers. This was seen as a way of splitting units into haves and have-nots. “Two sorts of hospitals will emerge from this practice: those who have the ability to earn, and those who do not”. There was more chance of survival for those units who could earn while service to the patients in the have-not units might be reduced.

Perception of resilience in people:

“In general, people have been terrific”. Some people took the opportunity to leave but a lot of people demonstrated loyalty and stayed on. While at times there were interpersonal tensions which might have been classified as symptoms, by and large people handled the amalgamation very well. One survival technique which was adopted was to stop trying to support too many people, and instead, concentrate on one’s own survival from one day to the next. People’s resilience and their ability to survive came also from discovering that they were being well-treated in comparison with others. At one level this allowed people to tell themselves that they would be OK. This ability of people to feel that they had managed

to survive should not be discounted. It meant that they could have a reasonable degree of confidence that the organization would make a commitment to them and therefore “they are not desperate to jump ship”.

The Beta Hospital

The Beta Hospital began its life as an army hospital in 1941. Prior to amalgamation it had 2,002 full time equivalent staff. It occupied 21 hectares of flat land consisting of over 100 low and widely dispersed buildings. It provided both general and specialist services, mainly to veterans and their families, with a small number of beds for the general population. It was a teaching hospital, part of the Alpha and Beta Hospitals Clinical School. Its mission was to provide acute care and comprehensive quality care to repatriation beneficiaries and the community, while committing itself to teaching, research and health promotion. The major themes of its philosophy were care, compassion and excellence.

The culture of the Beta Hospital was people-focused, patient-centered and humane. This hospital was brought up in a stable and well-protected environment under the Commonwealth system. Individuals in this environment had developed a very nurturing attitude and had a positive view of human nature. The atmosphere in this establishment was caring and friendly. Patient care was highly valued. There were feelings of “family” among workers. The long tradition of the veteran culture gave them a sense of history and emphasis on care for the old. Hero-making was not encouraged at the Beta Hospital. Being outstanding, unique, or promoting individual accomplishments were not attributes

that were reinforced. Conformity and consensus were prized more than individuality. Being responsible, real effort, hard work, bringing out one's best ability to contribute were also prized virtues. A sense of contentment derived from being a doer and a quiet achiever. Honesty, integrity and morality were qualities that were admired.

The Beta Hospital Interviews

Perception that staff at the Beta Hospital had been well prepared for coming into the State system from the Commonwealth:

Senior management, and in particular the Chief Executive Officer at the Beta Hospital, spent a lot of time and effort helping people at the hospital negotiate the transition into the State system and in getting them to understand that the amalgamation with the Alpha Hospital would then go through. This CEO realized that the changes were going to be very difficult and so he made a huge effort to give people hope for the future in a very honest and sincere way. This was done in stages. Work began five years before the change-over from Commonwealth to State with the setting up of think tanks. There were endless meetings to discuss how to present the Beta Hospital so that the State would want to take it on and to examine how the Beta Hospital compared with the Alpha Hospital in terms of strengths and weaknesses and in terms of where the two hospitals dovetailed. As a result of these discussions, two years prior to the amalgamation, the administration deliberately funded some hospital areas and cut funds to others, so that when the hospital was presented to the State for amalgamation it presented attractively in areas that were complementary to the Alpha Hospital, and not in conflict with it. "This was in sharp contrast to other States where some similar hospitals were jettisoned by the State".

Another way of helping staff to deal with the changes was to introduce the concepts of a better business planning process, and quality improvement teams. This was driven from the bottom up by getting local work groups to start putting up what they would like in a business plan. This was not an easy thing to do during a period of major change and it was not completely successful, but it was a good way to keep people interested in what they were doing, and getting them to work together on particular projects. “It’s a great way of managing irrespective of whether you are going through major changes or not”. The challenge for people was that they did not know what was going to happen to them, but it was obvious that if they weren’t performing well the outcome would not be good. People were going to be entering a very competitive environment so their best hope was to do well. It was very much an exercise in preparation, where the idea was to get ready early so that when the transition occurred people in the hospital “could hit the ground running”.

As well, a series of overt strategies were put into place to ensure that staff at the Beta Hospital were always kept abreast of developments - an information infrastructure. This took a number of forms. One was the development of a team-brief concept, so that a cascading of information was accomplished economically via a core of individual representatives from across all disciplines in the hospital. Relatively senior representatives attended a management forum which pre-dated the hospital briefings. At this forum the CEO covered what the oncoming changes might mean for the organization. Forums were held fortnightly at a regular time and were well-attended. The agenda included specific topics (sometimes with recurring themes) on issues such as how the transfers were proceeding in other States, so that everyone was aware of what was happening nationally.

People attending the meetings would then report to the next level of supervisor, and this would be repeated so that the information had reached the lowest common denominator within forty-eight hours. Because of night shifts, the nursing staff had its own infrastructure to convey the information, which was accomplished at ward change-over time. “Feedback indicated that the team-brief concept was working well”.

As frequently as these were needed (monthly at a base level of frequency), staff open forums were held. These attracted anything from one hundred to six hundred people. They dealt specifically with a range of issues which were handed out on an agenda, but staff could ask about anything. A written bulletin was put out, usually fortnightly, that reiterated what people had been told. About once a month an afternoon tea was put on by the executive and all people were encouraged to come and talk about their concerns. As well the CEO and an executive officer did regular work-place rounds of meetings, to talk to people within their familiar working environments. “They could talk directly to implications for the workplace there”.

An analysis of the workforce was conducted by a clinical psychologist associated with the hospital. This represented an attempt to understand each audience, and work out what level of support was still needed. It found, for example, that doctors and senior clinical staff needed something extra, so a meeting was held for them over and above the other meetings. They needed to understand the complex issues which related to them more clearly.

In the relaying of information there was care taken to ensure that the language used in anything that was said or written, was made understandable to the target people. The

language was always modified to suit the audience, whether that was doctors, administrators, cleaners, and so on, and this was a deliberate policy. There was a huge multicultural staff at the Beta Hospital and it was important to understand each culture and how it stood in the organization. In all this the Beta was streaks ahead of any other comparable hospitals in other States. “Canberra was monitoring the process and giving the Beta this feedback”.

At the Beta Hospital a system was developed to manage the process of job offer and selection which accompanied the hospital’s transition into the State. Throughout the process people were offered counselling, and a staff counsellor was provided. Group counselling was also provided, as was financial counselling. As well, there was a huge consultative structure developed to protect the interests of staff, and to help staff understand that they would have to take a loss. Nevertheless, staff were generally offered an equivalent job in the State system. This concept of “comparable job” entailed offering a job that was similar in duties to the one performed within the Commonwealth structure, and within a salary gap of plus or minus two percent. Where people (a minority) had to be offered a non-comparable job, they had the right to accept it or not accept it where either the duties, or the remuneration, or both, were different to a comparable job. If you were in a non-comparable position, you had to be placed in State employment, or failing that, you would be offered a voluntary redundancy package and eventually you would be cashed out. Most people in this situation agreed to take a non-comparable job. The incentive was that you did better financially this way. The Commonwealth eventually paid five hundred million dollars to affect a smooth transfer of the hospital to the State. Staff really focused on threshold issues, such as the prospect of minimal life changes, as an outcome of the

transition. While they would have a different employer they would have the opportunity to work across more sites. They would have portability of superannuation (they could stay with the Commonwealth scheme if they chose) and female staff would still have access to twelve weeks paid maternity leave when they transferred to the State. Through all of this, management took the position that if staff wanted packages, they would get them. “Post transfer, the hospital really wanted people who would be happy to work”. The CEO saw the process as one of “riding the tiger”. “You have no real control over it and it can take you anywhere so you just have to go with it”. While the executive always made it clear to people that this was the situation, it worked hard to achieve positive outcomes.

Perception that the transfer of the Beta Hospital into the State system from the Commonwealth had detrimental people effects:

The Beta Hospital came into the State system in January, 1995. At the time there were about three thousand, three hundred full-time and part-time people working within the hospital, who were put through an involuntary process and suffered enormous stress. “The Commonwealth did the dirty on these people”. It wanted to get out of providing direct health care. It wanted to jettison all hospitals like the Beta in each State. Eventually all of these were either transferred or sold. The staff at the Beta campus were faced with the possibility that the hospital might go private. This had led to two years of uncertainty, and created enormous angst and uncertainty. The process of leaving the Commonwealth presented a psychological barrier that had to be overcome.

“It wasn’t a massive problem initially until it became more likely”. At this time people started to become more concerned, and it was then (by about 1991) that people started to

leave. The people who left at this time were young professionals who at that stage of their lives wanted to cement their careers. Other people, those who were in demand, decided that they didn't want to put up with it when they could go off and get another position. While a lot of people were in place planning new services for the future, this was difficult to take on board because you didn't know what the future was going to be. In this situation a lot of initiative was stifled in terms of big picture projects.

Eventually a lot of people took voluntary departure packages [VDPs], which was not as it turned out, necessarily, the right choice. Some people had been ill-advised. For example, this was the case with someone on \$26,000 taking a VDP worth \$26,000 but with no guarantee of a job afterwards. For a lot of people it was the only time that they had been offered \$26,000 in cash. It was not something that they should have been advised to do, and they had been provided with other financial advice and counselling, "but if they chose to do it, then they chose to do it".

Perception that blowouts existed before the amalgamation which made budget reductions in the hospital system necessary:

Pre-amalgamation, all hospitals in Melbourne had huge budget overruns, and this needed attention. The way in which hospitals operated previously was for a hospital to get a new unit going, such as a liver transplant unit, and then the Health Department would have to take it on. However, post-amalgamation hospitals were no longer allowed to have budget overruns. Instead, they had to accommodate budget cuts. "Expenditure needed to be cut as there was too much fat in the system". What really happened was the end result of people trying to deal with the costs of health care, with an economy that was having trouble

affording it. All the resulting changes have been to try and cope with increasing demand but with diminishing resources. This increased demand is partly an issue of ageing, as people are living longer, and partly an issue of increased expectations, in that people are more aware of the availability of health care and the way it can help them than they were twenty years ago. “People are expecting a level of treatment or outcomes that they were not expecting twenty years ago”. Coupled with this expectation, particularly in the last ten years, is that we have had an economy which was having trouble dealing with that expectation, particularly with delivering tax dollars to health. This was compounded by a Commonwealth system where there were shared responsibilities (State and Commonwealth) for health, and both Governments were having difficulties with coping. What this led to was “cost-shifting”, or at least the practice of not accepting responsibility for the job and trying to off-load it on to someone else.

Perception that some advantages have emerged from the changes to the health system and with amalgamation:

While there have been some “quite stunning changes to health pursued for cynical financial reasons”, this has had some positive outcomes. The process of divesting budgetary control of hospitals to the networks and giving them autonomy was one such positive outcome. Within this structure individual hospitals have clinical service units, or collections of like disciplines, which now also control their own budgets. The idea of this was to ask the people who do the work (the field workers) to decide how to spend the money. Moreover, the regionalization of the health care system was set up, in principle at least, to facilitate the eradication of duplication. Theoretically, the money which was saved by this measure should have come back to the patient. Additionally, the old system of governance was

inherently wasteful. Institutions protected their own interests and this was mostly because they were governed by Boards of Management who were mostly interested in preserving the rights of their own institutions. Each Board managed an institution “which had a history of baggage associated with it”. What the establishment of Networks, along with the abolition of Boards did, was to make the perpetuated self-interest disappear. It “streamlined the functions”. The new Network in this area has meant that forty-odd Boards of Management have been reduced to seven Boards, while four hundred-odd Board members have been reduced to fifty. What we have now are Boards of Directors, not Boards of Management. They can think strategically at a macro level. They do not need to know the day-to-day detail of running a hospital. Historically, Boards of Management looked at operational issues. Now this is left to the various executive functions of the individual campuses. Moreover, the parochial views of the old individual Boards meant that they saw themselves in competition for scarce health dollars. Now, with the Network structure, they have to cooperate. This has meant that clinical services have been picked up which previously operated in isolation at the various campuses. A one-wide Network program, for example a Network Aged Care Service, has been created. This is real economy of scale. For example, if you have five discrete services, each requiring staff and equipment with a safety net factor, and then you combine them all, you can drop to a core level. It does mean that staff has to transfer (a transmigration of staff), as well as leading to some reduction of staff overall.

Perception that the provision of services under a Network model has not yet been resolved:

The Delta Medical Centre is still in a period of acute change. There is still a lot more uncertainty to come. This is mainly because the Network is still agonizing over whether it

is going to run as a series of programs or as a series of institutions. If it were to be run as a series of programs, then the hospitals would just be locations for a number of programs. The question then is one about service provision. You wouldn't create irrational services. If specific services are needed in a specific area, that is where you would provide them. "You would hope that there would be a rational approach to planning where the services are going to be located".

"Institutions are important". Where patient care, which is the end result, is concerned, the trick is to coordinate patient care, that is programs, within an institution. People feel that they own their institutions. You can hope that in the future they will feel like they own the Network, but that is going to take a long time and it will be very difficult because the bigger the organization is, the harder it is to be owned. People feel like they own their own work groups of ten very easily. They also own locations, and they own the people they talk to every day. While you can get someone to coordinate programs at the Network level, the organizational glue that holds these programs together seems to work better in the stand-alone institution, than in a Network.

The new Network Board sees itself as a Board of Directors rather than as a Board of Management. This has not been like the old hospital Boards that used to get very involved in management and in wanting to set directions. The new Network Board has not had much of an impact, and it has been hard to see any tangible evidence of management. "It might have been better to have established a new individual medical centre rather than one which was the sum of the two hospitals".

Perception that the Alpha was not well prepared for amalgamation with the Beta:

At the time of the announcement of the amalgamation, “there was a gnashing of teeth at the Alpha accompanied by petitions, submissions and howling”. There was no belief on either campus that the amalgamation would be a 50/50 thing. The Beta staff felt that the Alpha would take over the Beta Hospital wholesale. Meanwhile people at the Alpha were screaming about the division of the resources. This was unrealistic when you considered that the Alpha came out very well in the division of the spoils, but at the time, the Alpha people were unprepared. Moreover, the Alpha was in a worse financial position than the Beta. They were heading towards a deficit and possible bankruptcy. At the Beta Hospital people were also in shock, but they were more prepared and had been already thinking about the situation.

Perception that amalgamation with Alpha was more difficult than integration with the State for the Beta Hospital staff:

It was impossible to predict how difficult the amalgamation would turn out to be. The integration seemed to be easier because everyone was in it together. Everyone was working towards a common purpose. Basically the Government had bought a peaceful transition. Everyone who left was given some sort of reasonable compensation for leaving. In a situation like this, when you are dealing with peoples’ lives, this was a good investment because there was less long-term damage. It produced an outcome without industrial disputation and the hospital could keep on servicing patients.

“Amalgamation was a very different process”. There was no control over what was happening. Staff had much less say in the amalgamation. It seemed like the State was

much less interested in what was happening to people, or it just didn't understand. The Government said that people weren't losing their jobs, they were just amalgamating, but the Government had no idea what that meant. A downsizing is difficult enough but "an amalgamation is the most difficult form of downsizing you can have". It wasn't just a question of getting rid of people. It was mixing and matching and choosing one location, and all of that.

Perception that the amalgamation of positions were influenced by political considerations:

"This could be seen in the appointment of Director of Radiology which was a very political appointment". The Beta was considered a "country cousin" hospital, while the Alpha was seen as a leading teaching hospital. It took a long time to choose a selection panel and finally it was a hung panel because of all the politics that were going on. It then took the panel five days to decide that it couldn't make up its mind. Another panel was then appointed, but people assumed that it was going to be a political decision. The Alpha applicants just assumed they would get the positions, but in the end the Beta applicants did just as well. Medical appointments went to the Alpha. This was probably because the university had a lot of say in the matter of medical directorships. Appointments to supportive medical services went, largely, to the Beta.

Perception that budget cuts were as much a problem as the amalgamation in leading to reductions in staff and in hospital resources:

People were left under stress because they were trying to cope with how they were going to manage. The amalgamation did not help, "but the real issue is the budget cuts that were implemented". These two things were additive. It must be stressed that throughout the

process of amalgamation the State Government was dishonest, and from its inception, the Network was dishonest. If people from the beginning had been told that a 700 bed hospital was going to be slashed to a 350 – 400 one, they would have been upset but they would have had to accept the reality of the situation. Instead, people were told that everything was going to be alright.

After getting positions, heads of departments [the winners] faced the inevitability of the budget cuts. Department heads had to deliver the budget reductions, which meant staff reductions. The departments wanted to consolidate units on one campus or another where there were still two units existing. This made people redundant. Because of the pressures to save money, units over the two campuses were amalgamated into clinical service units [CSUs] which then became accountable for everything that went wrong. “They are at the end of the line of blame”. People were encouraged to blame the clinical service unit instead of the Government. The Government could throttle the supply of money to the units and was totally in control of the cash, while at the same time it accepted no responsibility. At the same time the managers of the units had no clear understanding of their expenditure, and everything was seemingly done in a void. The CSU directors were good clinicians who were forced to become managers. They needed to be a mixture of politician, accountant and financial wizard, however they went into the CSU thing without really thinking it through. The job was top-loaded onto people who were untrained and unwilling, and who often had no intention of changing their previous working style. It could be said that the amalgamation was the most difficult thing people had ever experienced in their working lives, because the outcome was about more than integration and amalgamation. It was also about funding, which aggravated everything. While people

thought they could manage the transition smoothly, the process was extremely brutal and corrupt.

While people struggled to take on the basis of a new accountability, the resources they were given to do this with were very tough bottom-line resources. “The economic rationalists had taken over”. This meant that the work environment became appalling. Money was shifted away from the hospitals. There was a real decrease in expenditure. The majority of the money went on salaries and nothing was left for the setting. The difference could be seen in small things, basics such as food, and comfortable chairs which were not replaced. When someone in a department announced that they were leaving, this was seen as an opportunity to make a budget saving. Before, you would have worried about this being a loss of expertise and talent. Managers were supposed to produce results for money. They were asked to distinguish between a profitable case, as opposed to an unprofitable one. Managers had to learn to work with profitable cases more quickly, to offset the unprofitable ones. This was seen as a hot political area. Furthermore, the new economic practices created problems for the education of future professionals, where time was needed to allow hands-on work with the patients. But time meant money, and the same juggling process had to go on here.

Perception that there were winners and losers in the intense competition between the Alpha and the Beta hospitals for positions following amalgamation:

Because there was an amalgamation involved each campus believed that it had to be done their campus way. “Technically, it should have been the best process that determined who was chosen, but it seemed that what worked best was whoever yelled the loudest”. People

tended to see each other as deadly enemies because one or another was going to get the new job. People watched each other; there was a real suspiciousness that people had for each other. The rumour going around was that the Beta was going to be raped and pillaged by the Alpha. This was a perception rather than a reality, but it led to people being labelled as either an Alpha person or a Beta person. Very little was done to dissuade people of this perception on the Alpha campus. The barriers at the Alpha were at the executive level, where poisonings of the mind went on by some people, and “particularly by one who ruled by fear and inuendo”.

The competition for one job as manager of an amalgamated unit led to intense rivalry. It was an awful, disgusting situation where the existing two departments became really polarized and where one-upmanship games were played. “It was a fight to the death”. There was an atmosphere of winners or losers because what transpired was not about individuals, but about playing winners and losers games. There was heightened tension.

Eventually this activity had its impact. Some people left, some people stayed. The losers who stayed had a fairly difficult time. They probably didn't do themselves any favours by staying. A lot were disruptive initially, and if they did not become reconciled they remained very unhappy, and openly destructive. Those people who stayed, but who were not going for positions, were mainly preoccupied with how they were going to work in the new regime. Some people just didn't want to relocate.

In nursing, a lot of people were the sole bread winners. A lot of nurses' partners had already gone through structural changes in the workplace and had lost their jobs or had

been forced into early retirement. Nurses questioned how they were going to be able to pay their mortgages. There was a lot of pressure in this discipline that the older person should be the one to be ditched, because they had reached their use-by date. The general assumption was that the older person should make way for the younger, although this was never stated. As a result of this attitude, people in their fifties, who had particularly contributed to the development of the hospital, suffered immensely. They had to come to terms with seeing themselves as no longer useful. It suited some of them in the end to take the package, but the process was difficult, and it left a big deficit in knowledge and skills.

Perception that the organizational restructuring had negative “people effects” on the survivors:

Most people like a stable, routine environment to work in. They want familiarity, comfort and stability. With the transfer of the Beta Hospital into the State system and its subsequent amalgamation with the Alpha, there was a shedding of equivalent full-time jobs. Then, a further downsizing occurred post-amalgamation on both campuses of the Delta Medical Centre. This led to a period of profound uncertainty. The survivors probably only started getting stressed when they saw all their compatriots leaving. Lots of relationships were gone. Sometimes their job was then made more difficult because they had to do the job of someone else who had gone. “Some people felt that they had been sold down the river”. The survivors felt like everything was changing too fast and they couldn’t keep up. This could be seen in their difficulty in coping with new committees and groups which changed because management changed. Sometimes this was perplexing for the survivors, who felt like the earth had moved under their feet and that they no longer had recognizable parameters to work within.

The people most affected by the amalgamation were those at the lower levels. The support services such as the kitchen staff, the porters, the laundry, the therapies and nursing were those who bore the greatest brunt. They were rationalized out of existence. The people who were least affected were the doctors and senior management. “Doctors were in the greatest denial. They just couldn’t believe that it had happened”. The main concern of all hospital groups was how much service would be left in the amalgamated hospitals. People saw what had happened as a plot to reduce hospital services, and this was not a stupid assessment of the situation as there was patently less money going in to the system while there was more demand. The environment in which the services were provided deteriorated. So much was taken out of the system that there was not much left, and this made things very tough, unbearable. “It was a good time to leave if you were planning to leave anyway”.

People who were unable to move on could not be trusted. They were manipulative. They remained within their old networks and they labelled you as Alpha or Beta people. They did not share information. They were angry and resentful. As well, people went on sick leave all the time. People looked unhappy and they were less tolerant of others. They were showing increased stress in the form of volcanic outbursts. There were more shows of aggression. There was more absenteeism and a sharp rise in the sickness rate. There were a lot of problems with sick leave. People were feeling that they shouldn’t bother, whereas before they would actually get up and make themselves come to work. In people who were coping minimally better, but who were still affected, you could see it in snide remarks, in expressions of dissatisfaction such as talking about it not being the same, and in less

willingness to participate in things like quality planning and so forth. Managers were just as affected as everyone else. They missed the interactions they had enjoyed with colleagues who could be trusted. “The camaraderie was gone and if they didn’t have it, then the rest of the staff didn’t have it either”.

People needed to be more resilient. The battlers needed coaching and support. People were floundering and communication was poor. There was an overall feeling that everything was out of control and that there was no one there to influence things. What resulted was a bunker mentality. People noticed symbols of the cost-cutting that had gone on, for example in the form of empty wards you still had to walk through to get to another section. When people had to adjust to working on two campuses instead of one, they found this a bit frightening. Staff were resistant to being deployed across campuses. People had to get used to things which were done that were different to what they had always known. At a day-to-day level people found these changes confrontational all the time. “People had to be dragged kicking and screaming into the new way”. Some staff found themselves in limbo, and their situations needed to be resolved.

Most people suffered terribly with fear and anxiety. All their energies were invested into coping with the events that had taken place which had changed their lives. There was nothing left to help them cope at home. Morale was very low. People had to learn to trust each other again as co-workers, and with what each worker could contribute. People who stayed on were angry and upset, fearing change and not trusting management. Staff were very suspicious of any industrial moves. Every implementation was regarded with suspicion. One example of this was when a full ward was transferred physically from one

campus to another. They had previously been having trouble with staff moving in and out of the ward as an outcome of the downsizing. Moreover, the ward had changed from a medical ward to a surgical ward. With the changeover, people were provided with orientation and they were given time to wander around and familiarize themselves with the new work place. They were also given a little party on the new campus to welcome them. This was because it had been recognized that the change was going to be difficult, but no-one realized just how difficult it was going to prove to be. As it turned out, even a small thing like night duty hours, which had been different on the two campuses (a matter of a half an hour difference) caused problems. The administration had to negotiate to get nurses to start their duty at the same time. A year down the track and staff were still crushed. They had been unable to internalize the big picture and why the changes to their working lives had been necessary.

Perception that doctors and medical staff lost their power base in the new system:

“Doctors were like mushrooms who were kept in the dark in the new system”. Most of the Network Board were non-medical people so that decisions were made without the input of medical people, and there were no channels for influencing decisions. This meant that most decisions regarding the medical centre were made remote from the centre, without consultation with people at the hospital.

A collective forum formerly used as a channel to discuss issues via the divisions, for example, the Division of Medicine, the Division of Surgery, no longer existed. The divisions still existed and had regular meetings, but they had been marginalized so that there was no longer a flow of information backwards and forwards between them and

management. The executive preferred to deal directly with the new clinical support units. This left a huge gap, It became a divide and conquer thing. There was no recognition allowing doctors to speak. There was no longer any collective representation for doctors. There was a hospital newsletter but that was seen as motherhood stuff.

Perception that economic rationalism incorporating organizational restructuring in the Victorian health system led to patient problems and a deterioration in patient care:

There was a movement of patients into the “haves” (those who were privately insured and could go to private hospitals or units) and the “have nots” (those who had no private health insurance and who had to stay in the public health system). The “haves” got a quicker service and more time with medical staff. What happened around the “have nots” was that people were trying to think of ways to constrain costs and maintain quality while controlling the total budget. The way the State did this was to try and find a better measure of activity than hitherto, and therefore it decided to fund hospitals on an activity-based funding scheme. “In theory there was nothing wrong with this. Its success just depended on whether you put enough money into it”. What happened was that the Government used a lot of organizational chaos to hide what it was doing in terms of budget cuts, for example, the introduction into Victoria of case-mix funding. When it was introduced very few people understood the implications of using it. Case-mix was meant to standardize costs, and this is fine so long as you get the funding per unit of activity right. What the Victorian Government clearly did was, while they introduced case-mix funding, they simultaneously introduced budget cuts.

Case-mix was being used to investigate people who were using up more resources than they should. Under the case-mix method of funding, diseases were grouped according to resource use along the lines of a decision tree model. This meant that if someone stayed longer in hospital than they were meant to according to this formula, the hospital would not be paid for it, so hospitals would push patients out. Hospitals were now encouraged to push patients out. People could no longer stay in hospital and recuperate properly. The results could be seen in the number of hospital re-admissions, however, while a lot of patients wanted to come back they found this hard, and they had to go back onto the waiting lists. Allied Health used to spend time with these people getting them better, but with the introduction of case-mix people went through the system too quickly.

Funding cuts and case-mix had an effect on preventative work. For example, dieticians were doing less preventative work because they were seeing more acutely sick people. People with serious cancers were coming in later because they couldn't get a bed or because they were unable to get onto an operating list, so that dieticians saw them when less could be done. This was occurring within a population which was ageing, and where people were presenting with a lot of existing problems, and then they got cancer. What seems to have been happening is that the Government was trying to maximize throughput for the available amount of money. To a certain extent this was achieved, but to another extent they were kidding themselves. People in the system generated numbers without generating increased activity. "If you get paid according to the number of patients you treat, you count patients better", so a lot of the claimed increased activity was really people counting better, rather than people doing more.

Perception that there was a big cultural difference between the Alpha Hospital and the Beta Hospital at the time of amalgamation:

The Beta: There was very much a customer focus at the Beta Hospital. People were really friendly; they were a caring and sharing group. People were committed to providing a service. It was less about who they were and more about a focus on the role, on what people were doing. There had been a Team Quality Management process that the hospital had gone through which had a big impact on people. People had values and beliefs because they were treating veterans. It was less about politics. “There were no people strutting around with big egos”. It was a much more relaxed environment. The hospital was small enough so that things could get done. Its design was open, fostering interaction. Management walked around the hospital freely.

The Beta Hospital was a hospital with a history of veterans. When the veterans came to the Beta, they had all had something to do with the war and this was a common bond which was unconsciously instilled into the staff. “The Beta had a unique culture of support”. It could be seen as having a large family type structure which was very supportive of the individuals working there. People were made to feel part of a close-knit community. This helped people to feel more supported at the time of change because they could interact and talk with colleagues.

The Beta operated in a very structured manner when it was part of the Commonwealth. There were more feedback loops and consequently more accountability. The clientele was predominantly Anglo-Saxon. This meant that many of the staff had become used to

dealing with a homogeneous group. Consequently they weren't prepared for the ethnic nature of the public hospital clientele when they were exposed to this.

The Alpha: At the Alpha Hospital people were very segregated. It was very bureaucratic. There were a lot of power plays going on there. People were very competitive for resources. While there were a lot of very good people in research and teaching, they had to be very entrepreneurial where finances were concerned. There was a bit of a tendency towards snobbishness on the part of some people who thought they were the best. It was somewhat hierarchical from the professors down. A lot of it was about who you knew. "A lot depended on whether the director was a good operator".

There was a degree of distrust of management at the Alpha. For example, particularly in nursing, the Alpha was seen as having a more directive nursing administration. As well, a lot depended on where your medical discipline was in the pecking order. Psychology had very little influence, so it was in bad shape. Nuclear medicine was in good shape because of the director's political activity. The hospital operated in a very political way. The university was very prominent in the hospital and this helps to explain the hierarchical nature of departmental influence.

At the Alpha Hospital units were given budgets, but they were not held accountable. It was a linear system with no feedback loops like the Beta. The clientele at this hospital came from everywhere. They had no common background. "They couldn't talk about which RSL they belonged to". People working at the Alpha seemed both depressed, and

oppressed, because of the climate of financial oppression. They worked in sub-standard conditions. There was low morale. They seemed to be ground into the dust.

Perception that the amalgamation produced a grieving process which people had to go through:

The biggest thing following the amalgamation was the grieving process that people went through. It followed the Kubler-Ross model. It included all the stages. Different people could be seen to be in different stages at the same time. There were still people in denial. These people were stuck. "People were in a sort of shock following the announcement of the amalgamation. They had to digest a new story every day". Afterwards, a lot of people were still grieving and this had an affect on absenteeism which could be seen to fluctuate and go up and down in spasms. People became very critical of the new management. They expected management to do everything, and they ceased to take responsibility for themselves. There was a lot of looking back at the past and reminiscing and hoping that it would come back. The organization that people had helped to build had been dismantled. People missed their network contacts.

Perception that a stable outside environment and inner stability helped people cope better with the stresses of organizational change:

The more stable the home environment was, the better people coped with the stresses at work. Anyone having a problem at home, such as a marriage break-up or a sick child, presented in disaster mode and they showed this by increased absenteeism or by breaking down and crying on the job. The people who couldn't talk were the worst off. Those people who showed symptoms were usually handled by referral to psychiatry, or by being

given annual leave, or reduced hours, and so forth. Even with those who couldn't express their feelings, someone on the team would usually find out, which eventually would lead to supportive action appropriate for that person.

At the time that the new appointments to the medical centre were being made, people were afraid to open up to personal problems because they felt that this might cost them an appointment. They felt that they had to be seen as coping. They also had to be careful not to be seen as querying a management position, as that might look like they couldn't cope with change. You couldn't even make an objective comment if you were on staff. "The minute you criticized the new regime you were seen as stirring the pot, as reactive, or as not coping". Some people who had lived through loss and insecurity earlier in their lives became more conscious of the need to hang onto their positions and maintain job security.

Perception that there were people who had moved on:

People ended up essentially in one of two piles. Those who moved on psychologically were in one pile. They got on well with the new people who came in, and they came through it very well. While the downsizing affected them, they anticipated the changes. This applied to groups such as thoracic medicine and oncology who had to squeeze back their resources. They dealt with it by re-positioning themselves across both campuses ahead of the amalgamation, and so they came out of it well.

If you decided that you wanted to stay, you just had to accept that you needed to start again. People were left isolated and had to establish completely new networks. They had to accept a shift in the power of decision-making. Survivors who moved into senior

positions brought a new perspective to the way decisions were implemented and made. There was a subtle shift in focus that you had to become aware of.

People then moved into to a period of consolidation. Things were still difficult and there were constant reminders of what had happened, but people were finally moving on. They were looking to the future more than they had been. From being very caught up with expressions of how nothing was right in the new environment, people were now seeing it in terms of this might be a better way of doing things. “We can work together on this”.

Perception that the Delta Medical Centre had to start from scratch to develop its own profile:

“It was a whole new ball game”. At the time of the amalgamation a broom was swept through both of the hospitals. A lot of people left at this time and the executive office had to be revamped. People were brought in from other areas and all were placed on high salaries. New positions were created, for example, the Director of Public Relations, the Director of Patient Services. All these people drove nice cars and had lots of perks. They were “whizz-bang” people but unknown. They’d had no personal contact with people who had worked in the hospital for many years. Before this you always knew people in the front office and you could stop by for a chat. In the new institution, things had become de-institutionalized, but also de-personalized.

The amalgamated hospital had no history. It took time for it to be recognized as a new organization which had no history. The hospitals had gone through a very painful process which was both physically and psychologically demanding. However, the Delta Medical

Centre survived, and it would go on to produce a magnificent outcome. It would create a new culture and a new identity as a new history was built up. The Network was still developing a personality. It was still at the toddler stage developmentally. It was past the crawling stage but with a long way to go. Part of the Network's task was to realign the thoughts of its constituent members so that they could see themselves as no longer standing alone, but as independent members who were part of a composite structure.

Summary

To summarize, as the interviewees told their stories it became clear that there was a lot of common ground in the perceptions of the Alpha Hospital group and those of the Beta Hospital. For both groups there were three overriding and interrelated themes of process, politics, and people.

At the outset there was a great deal of support given by the interviewees from both hospital campuses for the State Government's implementation of amalgamation. The need for an amalgamation of hospitals, as well as the restructuring of health services across the State, was seen as long overdue. The politics of economic rationalism, viewed ideally, anticipated the restoration of financial viability to the health system, while it encouraged a view of a new flexibility and accountability operating within it. Everyone in the system would benefit: from the deliverers of the services, to the client base it supported.

Both groups could refer to radical organizational change in their former hospital settings where there had been relatively optimistic outcomes. More recently, the Beta Hospital interviewees had survived a huge transition, an integration from the Commonwealth to the

State. While the wash-up from this had resulted in loss for some people, the Beta people had been involved in the process from the outset, and they had retained a semblance of choice in determining their own futures. The Alpha interviewees had the model of the Gamma facility to remind them that an amalgamation could be achieved without major bloodletting, and with appropriate sensitivity being paid to the feelings of the people involved.

A feature in the narratives of the interviewees was how each group saw themselves in terms of organizational culture. There was agreement that the perspectives of people involved in the amalgamation were influenced by their earlier institution's history. The unstated implication of this was that differences in history expressed in the organization's ethos and culture were an important determinant in how people from different organizations gelled and worked together in a new organizational setting.

As the current amalgamation progressed the narratives of both groups of interviewees reflected their increasing disenchantment. There was dissatisfaction because of the way this amalgamation had been handled. There was a consensus amongst both groups that the amalgamation process was poorly managed by insensitive people who had politics, rather than policy, in mind when the amalgamation was implemented. The amalgamation was driven by the Health Department and by people outside the health profession who were not interested in the welfare of people who were caught up in the change. Politics was involved in determining how people were appointed to amalgamated positions at the executive and management levels. Appointments to the new medical centre were described in terms of 'winners and losers'. Management personnel found themselves in situations

where they competed for shrinking appointments within their disciplines. This was a scenario in which former colleagues, who had hitherto been regarded as extremely competent, were seen as having become disempowered. People were marginalized, sidelined, and ultimately became redundant as an outcome of the amalgamation process. There was a perception that many appointments were externally determined by bodies such as the Health Department, or the University, and that this had an extremely detrimental effect on staff solidarity and morale.

It was more than just the amalgamation alone that was seen as having been particularly hard on people who were attempting to find a footing working in the new medical centre. The consensus was that this had been hard enough. Nevertheless, the situation was so tough because the amalgamation was accompanied simultaneously by other changes, such as the budget cuts and the implementation of new procedures such as case-mix. As the interviewees understood it, the State Government, through its handmaiden the Health Department, and in accordance with the constructs of economic rationalism, had instituted an amalgamation of hospitals to produce the Delta Medical Centre, and had also created new administrative structures, or network, for the delivery of health services. What had made the situation more intolerable was that simultaneously, it had drained the system of resources (the budget cuts) and increased its requirement for a more efficient throughput of patients (case-mix).

Along with the structural changes, these tough new measures had an extremely negative outcome on the physical and psychological well-being of employees at all levels. This state of affairs was clearly identified by the interviewees in both groups. The “survivors” shared

their observations of increased sickness, absenteeism and sleeping disturbances amongst their colleagues. As well, they reported heightened anxiety, loss of morale, grief and anger. All of this culminated in a litany of self-defeating and manipulative behaviours, as people failed to adjust to the changed environment. People, based on their earlier experiences, had expected a reasonable outcome for themselves and for their colleagues, as well as for the patients. However, what had resulted was less than reasonable. The working world had changed irretrievably and there was no longer any certainty to be had in people's working lives. Moreover, while several colleagues had tried to be supportive, there was very little formal help given to people who were going through the nightmare; very little professional counselling or other forms of assistance. Nevertheless, in spite of the profound negativity of the situation, there was some optimism expressed by both groups of interviewees, that there might be some "light at the end of the tunnel". Interviewees shared a positive view of the potential for resilience in many people, as well as for the possibility of a period of growth and re-identification with the new structure in the future.

The Follow-Up Interviews

The material in this section is compiled from the follow-up interviews conducted with each of the participant interviewees. Interviewees were asked a number of structured questions to elicit how they were managing at a later stage in the new structure. Once again, interviewees' responses reflecting their opinions and feelings, have been consolidated by the researcher. Once again the responses of all the interviewees have been woven together to speak as one voice.

What are your feelings now about the Victorian Health System?

People continued to have serious misgivings about the Victorian health system. The public hospital system was still underfunded and there were “stresses and strains”. While there was enough money in the system to perform the day-to-day activities, there was not enough to maintain the infrastructure or to promote overall development. Insufficient consideration had been given to areas such as medical education and medical research. The talk was still about budgetary constraints, and nervousness about possible privatization. The challenge which remained was to do the best with the total health dollar available. The major issue was one of the quality of health care delivery. While more was being provided for fewer dollars, the human aspects of in-patient care were being sacrificed for the technical aspects. The challenge was “for individual practitioners to reconcile the patient advocate role with the resource allocation role”.

The role of Government and a lack of communication and sharing of goals between executive management and those dealing with patients on a day-to-day basis was an important issue. There were “different priorities”. The Government dictated that managerial people should have financial priorities, so that financial considerations were the ultimate determinants of everything that was done. This ensured that there was a fixed amount of money which could be spent. Departments were told to make choices between procedures. Unfortunately, this led to impossible decisions when patients needed several procedures. “This forced very hard decisions”.

People working in the system were not very happy. “It stinks”; “it’s stuffed”. Morale had remained low where staff was concerned. There were problems in the area of patient care

and with the access of patients to undergraduate students. Because patients were being discharged too early, students failed to get an idea of process, and nursing staff, who themselves were affected by staff cuts, were 'too busy shunting patients through the system' to look after their needs. In general, the whole concept had become more like "an assembly line where people were there to perform a task and then move the patient on". While the care that was given was still wonderful, this was because of the enormous efforts that were made by the professionals involved. Nevertheless, "the whole fabric was burning out and people were leaving. This could only lead to a loss of skilled knowledge and corporate knowledge".

What are your feelings now about your own current situation?

This question elicited a variable response and some ambivalence. Some people were enjoying their situation in the new hospital structure because they had taken on new managerial positions or challenges which they found extremely satisfying. While they remained depressed about what was happening in the health system overall, they were able to do good things in their own departments with the limited resources available. As well, the atmosphere had become much more relaxed. "There was a little less Alpha versus Beta stuff". There was a lot of work going on in the area of developing team values. This couldn't be done at the time of the amalgamation when the concentration was on process, and when people were hurting too much. Now there was a sense of coming up for air and people moving on. Nevertheless, there was still the foreboding of privatization to which people were philosophically opposed. "It's a monkey on your shoulders in case it might happen". While there were expressions of job satisfaction, "if I won tattslotto, I'd be out of the door tomorrow".

There was an issue of a lack of loyalty insofar as interactions with colleagues and hospital management was concerned. Previously one got a great deal of pleasure out of being part of a unit in the hospital. While there was still involvement with patient care which hadn't changed much, and you still did your job, there was less satisfaction and pleasure to be gained from the role because there was less contact with patients. Under the new administration the role was a more supervisory one. Your job was to make sure that that the unit ticked over and that the patients were cared for adequately.

Some people had come out of the hospital unwillingly, or had lost their previous status. This remained an unsettling situation for people who did not get managerial positions in the new structure. These people would have to go through further selection processes for some time to come. Even more parlous was the position of one administrator whose job had become redundant in the amalgamated structure. This interviewee was on income maintenance for thirteen months, but had been declared officially "in excess". This was a "very personal" situation for the interviewee, who felt "pretty bitter" about what had happened and who believed that his position had been tainted by association with the former Board and the former executive. From another perspective, the sadness of leaving was less personal but more about how the histories of both the organizations had disappeared and nothing better had come to replace them.

Leaving the hospital and the public health system was a "revelation" for some interviewees. Once you left the system you began to understand how bad it was. It looked alright, "but it is polluted and it makes you sick when you are living and breathing it". People in the

Victorian public health system still talked mainly about politics, and there was very little focus on the true meaning of health care. There was enjoyment to be had working in outside organizations, although there was a feeling of guilt about coming out of the public hospital system. Moreover, while other interests outside the hospital were worth pursuing, there was less involvement with some of the former more interesting in-hospital activities, such as organizational performance, assessing standards, and so forth.

How do you feel about the people who have moved on?

There were many feelings of regret expressed about those people who had moved on. For example, people from the old Board of the Alpha Hospital had become fragmented and there was no longer any regular contact maintained. There was a sense that people who had been senior people in the administration of the hospital had been treated in a very shoddy way. They had put in “an over and above effort”. “Any enterprise requires three things: money, good ideas and good people. It is easier to get money and good ideas than most people think, but the hardest thing to get is good people. The amalgamation process didn’t have any regard for the quality of the people”.

People acknowledged that everyone involved had to make their own choices, and that it was wrong to make judgements about those who had left. Some people left “because their values were no longer congruent with where the organization was heading”. Those people who left were often the most respected people in the institution. Therefore they would obviously be recruited from outside. It was a bit sad that some of these people left because “they had been remarkable”. One person who left had enormous integrity and sensitivity towards people. “He was enormously smart, intellectually able. He could predict”. For

other people it was a more personal decision. “If you feel that you can no longer contribute you need to leave because it starts to show”. Leaving could be fortuitous. Some people got better jobs. Others took a package and for them life became different.

“Change, of itself, is not a bad thing”. Some people had done well in leaving and they were happy. Other people had lost out because they were unable to get better or equivalent jobs. A number of people had left in unpleasant circumstances and they were very bitter. Some of these people were “pushed out” or they had “got stranded like a shag on a rock”. Other people were just glad to be rid of the place. They didn’t want to deal with the new executive, “all self-serving and scheming”. Life could be difficult if you had gone, or if you had stayed. A significant number of people left without any positive ideas about what they might do, and several were still languishing on packages.

The amalgamation had been a massive upheaval and this had led to a lot of attrition. A lot of good people had “jumped ship” and gone elsewhere. This was a loss. They had been a great team and this had been decimated. The organization missed their skills. There were no people of commensurate ability to replace them. The feelings around the hospital were different to the pre-amalgamation period. People now felt that it was just a job. “You do your job and that’s it”. No-one was looking at the long term. Those people who were left in the hospital faced a very uncertain environment. They had no sense of security or employment longevity, and this, they felt, would be worse in a privatized environment. After a period of uncertainty, it would take time for people to become productive. At the senior level, it would take time for the new people to gel as a team.

This was very different to how things had been in the past. In the past people had belonged to an organization in which they worked for a long time. There was “commitment to the philosophy of the organization”. People had been a team. They knew each others’ strengths and weaknesses. You always had a percentage of “new blood”, but there were also stable, experienced people who could draw on their past experience. Now they were all gone and had been replaced with people on contract, people who were scared to lose their jobs because they had no security of tenure. “They are yeasayers generally”.

How do you feel about the projected plans for the hospital?

The more positive view was that with privatization (there was a proposal to build a private on the proposed Delta Medical Centre site) there would be money to spend on a new state-of-the-art hospital. If this were to be done there could be a great hospital. A stable employer would bring opportunity as well as a new hospital. One would like to think that at the end something good would come from it. “The sooner it happens the better”.

More people were pessimistic about the perceived advantages of privatization than were optimistic, however. They were “not impressed”. Money that was being poured into hiring consultants, such as architects and designers, was coming out of other areas of health care. Everything would have to be specified in order to sell it to the new investors, so it would have to be costed and tendered out. It was inevitable that in this process parts of services currently offered would not be included, either intentionally or accidentally, and that this then “would be set in cement”. As well, costing had created other problems. Clinicians themselves would have to do the specifications. Thus they would be removed from patient

care. Moreover, while the hospital was so focused on the re-development, new clinical services, the life-blood of the hospital, were not being created.

There was a further concern that with privatization, the hospital would change in character. The hospital would not be able to maintain its role as a first-class university hospital. “The teaching side won’t sit comfortably with the profit motive”. The hospital would no longer be seen as a leader in many aspects of medicine. Patients were another consideration. What would happen to patients in the new medical centre in terms of how they would be looked after? There would probably be a need to change and patients would not be so well looked after. The people currently being looked after in the hospital environment frequently came from low socio-economic-status groups, or from a non-English speaking background. These groups would not do so well in a privatized system.

A lot of what was driving the call for privatization was the ideological claim that it would be cheaper and more efficient. But, it really was being driven by political considerations rather than anything else. If the hospital were to be privatized, it would be all about money and the organization would be looking to become even leaner. Private hospitals had to be in the business of making money. This would compromise services and erode the support for research and education. No preventative work would be done and it would degenerate into illness care for the very sick - very basic health care. In any event, according to some interviewees, it was unlikely to happen because there was an impending election and it would be so politically unpopular.

A SUMMARY AND SOME COMMENTS MADE

The material in the follow-up interviews was frequently a reiteration of the concerns and feelings expressed in the initial interviews. The survivors continued to be pre-occupied with issues such as budget cuts, the role of the Government in financial determinations of the hospital's activities, and its intrusions into the quality of patient care. A continuing decline in the morale of people, working in a system which was seen as having become more stream-lined, but less humane, was a cause for concern.

How individual people saw their own situations in relation to the new structure appeared to depend on how they had fared in the wash-up following the re-structuring. In general, people who had been successful in obtaining managerial positions tended to view their current situation more favourably. They noticed a more relaxed environment and the beginnings of a new group solidarity. This was not a universally shared impression. For some interviewees the management role had become more de-personalized and less personally satisfying, while the current situation for those who had lost positions and were still going through the processes of selection or job survival was even more precarious. Meanwhile, those interviewees who had left the public hospital system voluntarily were upbeat about the relief they experienced being outside of a sick system. All the same, they felt guilty about abandoning the public health system, and admitted that their new activities were often less interesting.

There was mostly regret and sadness about the loss of people who had moved on, particularly those who had made a personal and ethical stand against the new order by leaving, or those who were regarded as having made valuable contributions. There was also sadness for those people who had left because they had no place in the new structure. People agreed that while the change could be beneficial for those who went, for those who remained, this was seen as a loss for the hospital. Moreover, the people who went were often replaced by new people on contract. There was no commensurate level of skills, identification as part of a team, or sense of personal loyalty and commitment to the philosophy of the organization.

There was more apprehension, than support, for the projected plan of government to build a private medical facility. Most people were apprehensive about the perceived benefits of privatization in terms of its potential ill-effects on patient care. Teaching and research would also fall victims to such a misguided policy. The drive for privatization was seen as primarily an ideological decision which would further erode the well-being of the organization. Moreover, this was seen to be both unworkable and unacceptable in the then current political climate.

People from both the Alpha and Beta institutions were prepared to put their feelings on the line for the researcher over the course of this study. As it transpired, the interviewees' experiences and reactions included in the narratives followed a similar course, as they struggled through the amalgamation, in spite of differences in ethos and culture. The overall impression for the researcher is that while a restructuring of the Victorian health

system in itself was probably long overdue (this was acknowledged by many interviewees), and while some fall out could have been expected from the accommodations that needed to be made to achieve this change, there were errors in judgement made by the various governments involved, and by the Victorian Health Department in particular, which were continuing to cause the participants a great deal of grief and pain. How change management might be implemented to achieve a more favourable outcome will be looked at in more detail in the next section.

CHAPTER SEVEN

A HUGE CHANGE WHICH COULD HAVE BEEN MANAGED BETTER

Economic Rationalism Revisited

As has been noted at the start of this thesis, for the period from settlement until the late 1980s, health care in Australia was predicated on a philosophy of universal coverage and free care. This philosophy had a significant influence on the way in which hospitals, among other institutions, developed. The late 1980s, however, brought a sudden shift in thinking, and one which appealed to Australian governments of different political persuasions, at Commonwealth and State levels, as they acted to reduce both the National and State debt. The new policy was that of economic rationalism. Built on the idea that deregulated markets are the most efficient form of resource allocation, it encompassed a philosophy which promoted the use of competition, and which advocated consumer choice linked to user payments. Australian governments, both Commonwealth and State, have given expression to this philosophy by separating policy decision-making from service delivery functions, regulating the work of hospitals through contractualism and corporate management models, and requiring the individual consumer to provide for their own needs by purchasing health goods in a competitive market. Australian governments have argued that consumer choice (albeit forced) and competition (arguably artificially created) results in efficiencies. Indeed, a number of participants in this research agreed that change was

necessary in the health system in order to overcome the costly duplication of services and wasteful practices that were endemic in the delivery of Australian health services prior to the late 1980s.

Since the late 1980s, then, Australian governments had become increasingly non-interventionist. Nevertheless, the Commonwealth Government had perceived a need to influence the policies and practices of the States in order to implement its own policies (Palmer & Short, 2000). From 1983, the introduction of a universal health insurance scheme and free public hospital care via the Commonwealth-State Medicare agreements defined the formulae by which Commonwealth funds flowed to the States for the provision of care to public patients, and specified the obligations of the States in return for this funding. However, from the late 1970s, there had existed ongoing concerns about cost increases and about the management of public hospitals. From the mid-1980s, governments began to consider the problem of how to improve the process of allocating funds to hospitals. Commonwealth inquiries, for example, the National Health Strategy (1991a) report on hospitals, emphasized the need for reforms to improve the efficiency, equity and quality of services provided by both the public and private sectors ((Palmer & Short, 2000). Fiscal reforms such as COAG [the Council of Australian Governments] (1995) and PHOFA [Public Health Outcome Funding Agreement] (1997/98), were created to allow greater flexibility and administrative efficiency in Commonwealth-State financing arrangements in public health. Hospital accountability was also facilitated by the development of DRGs [Diagnostic Related Groups] and casemix measures of hospital activity. In 1985 the Commonwealth Government supported consultancy aimed at testing whether the DRG classification system, as developed in the USA, was relevant to

Australian clinical practice (Duckett, 2000). In this way the Commonwealth was active in encouraging the development and dissemination of casemix systems in Australia. At the same time there were ongoing disputes between the Commonwealth Government and the States, who believed that the Commonwealth's provision of free public hospital service was made at their expense. In the 1990s, in the face of such things as long waiting lists for elective admissions, criticisms of public hospitals escalated. Faced with a narrow and fickle revenue base, the States then set out to find ways to minimize their public hospital outlays. One way that State health systems met the challenge of raising capital was by co-locating private hospitals on the campuses of public hospitals. By 1997, and during the period of the current research, the public sector remained the most important component of the Australian health system. Medical services were subsidized directly by the Commonwealth Government through Medicare, which also provided funds to the States for the operation of their public sector health care system. Alongside this system, there also existed a small, and influential, private hospital and private health insurance industry.

The Victorian Health System Revisited

The manner in which the public health system was being managed had become a major political issue in the State of Victoria in the early 1990s, and the 1992 newly elected Liberal-National Government devoted itself specifically to the problem of improving the technical efficiency of the State's hospitals. To this end, the new Victorian Government pursued a number of budgetary policies in the area of health. These included public expenditure reduction, rationalization of services, the introduction of casemix funding,

increased managerialism in the senior public service, and a service-delivery emphasis for community health.

Soon after coming into power, the new government moved swiftly and decisively to impose cuts on public expenditure, shed public sector employees, and reorganize the administration of Ministries. The legitimacy of the new order was based, for the most part, on credible financial management and the maintenance of services, despite reductions in public sector expenditure and the health sector workforce. The emphasis was laid most strongly upon outputs and outcomes, rather than on the processes of policy-making. To these ends the Victorian Government set about the reformation of the administrative structure of the Department responsible for managing the health system, freezing all capital work projects, and negotiating new wage and enterprise agreements with Departmental staff (Barracough & Smith, 1994). At the same time, massive funding reductions were achieved "by obfuscating them in casemix funding rhetoric of hospital competitiveness and complexity of formulation" (Stoelwinder & Viney, 2000, p.220). In other words, by confusing the issue with talk.

An early attempt to achieve reform centred on casemix funding. This was a major, principal strategy employed by the State's Health Minister to improve efficiency in the area of payment reform. The size of the budget going to any hospital had been largely determined by past allocations. These in turn were influenced by the history of the particular hospital, the status of the hospital, and the capacity of the hospital to lobby effectively in the private arena of negotiation with health departments, and in the public arena with the media. "Some types of health care and some types of hospitals have more

'purchase' on the public imagination" (Draper, 1999). Casemix funding entailed the description of hospital activities as products within a "health market". Evaluations of this strategy were mixed, with the Victorian Auditor-General's office (1998) reporting both large increases in the technical efficiency of hospitals in the early years, and the belief, by hospital staff, that there had been an adverse impact on the quality of patient care (Duckett, 2000). This latter belief was held by some of the participants in this research, and was, arguably, strengthened over time by the manner in which the Alpha and Beta hospitals were amalgamated. Furthermore, it was felt, by some, that the casemix system might reward being "busy", but not necessarily reward "doing the right thing". It might also distort incentives for, or shift costs onto, other components of the health system. Hospitals might choose to concentrate on more "profitable" services, provide higher levels of some elective procedures, or discharge patients prematurely without sufficient domiciliary support (Lin & Duckett, 1997).

Another major reform following the introduction of casemix and the imposition of budgetary restraints (\$220 million was removed from hospital budgets over a period of two years) was the introduction of hospital networks, that would have considerable scope to develop the distinct health services indicated by the changing needs of the community the particular network was designed to serve. Each network was to have a growth path, and would incorporate a number of different facilities. In the case at the centre of this research, the network was to include a new community hospital, a women's hospital, an extended care centre, an infectious diseases hospital, and the amalgamated Alpha and Beta hospitals. Public hospitals, which until now had been run by their own Boards of Directors, suddenly ceased to exist as legal entities in their own right, coming, instead, under the control of a

network Board. This was another major change. Some analysts, such as Adeney (1997), feared that "what we have seen in the move to networks [was] a process of centralization of power in the hands of the network Boards and thus easier control of the system as a whole by government" (p. 274). Others felt that the aggregation of individual hospital Boards into a single network Board meant a curtailing of the desire of each hospital Board to maximize its own autonomy and size. Whatever the truth of the matter, the implementation of this strategy had an undoubtedly profound effect on many of the participants in this research.

In summary, then, the separation of health policy decision-making from service delivery by the Australian Government, led the Victorian Liberal-National Government (1992) to embrace a number of major health strategies – budget rationalization, casemix, and networks – in their efforts to improve the efficiency and effectiveness of the State health system. Any one of these strategies, and the way they were implemented, alone was arguably sufficient to cause a major disruption in the productivity of affected hospitals. Compounding this change in policy, in the network in which this research is located, was the amalgamation of the Alpha and Beta hospitals. Taken altogether, these changes had deeply felt, far-reaching consequences for those hospitals, and their staff.

Alpha plus Beta and Managing Change

It has been shown that many of the participants in the study came into the amalgamation with some enthusiasm, or at least with the acknowledgement that some change was necessary in a public health system, aspects of which were seen as having become wasteful and economically unviable. The impressions of the participants covering this period were a

powerful indictment of how they saw the management of the amalgamation during the period of its implementation, and its aftermath. The amalgamation of the Alpha and Beta Hospitals was a huge change, and it had a profound effect on people's sensibilities. In the case of this amalgamation, the narratives suggested that ultimately, the people involved came to see themselves as powerless, rather than powerful, and that they saw the leadership in the change process as repressive, rather than supportive. Their stories suggested that the economic and organizational benefits which they had anticipated would accrue from the amalgamation, had not materialized. To the people who were actually providing the health services, this amalgamation looked more like an exercise in opportunism, than a genuine attempt to implement effective change management.

Consideration must be given to the political and economic climate in which the events represented in this thesis occurred. Broadly speaking, in today's world, most organizations are operating in an environment of exceptional complexity, where financial operations on the other side of the world routinely have major impacts on the capacity to manage organizations at the local level, and where government, business, the bureaucracy, the environment and social activity are intensely intertwined. As discussed earlier, politics and economics at the Commonwealth level informed the movement towards policies of economic rationalism at the State level, which in turn dictated the quality and direction of the changes in the State health system and, specifically, those changes which were brought to bear on the public hospitals. These changes were extremely complex, and the administration of the policies, as the policies themselves, were extremely hard-core. It is arguable that the degree of change which was expected to be achieved in a relatively short period of time was unreasonable and that, with the best support possible, it nevertheless

would have been extremely difficult for the hospitals involved to have managed the expected degree of adaptation. As if the policy change and the resultant implementation of new and far-reaching strategies were not enough, two independent, culturally very diverse, hospitals were forced to amalgamate.

Institutions dealing with an organizational change, such as an amalgamation, often operate in a context where the pre-existing structure has been jettisoned, where things are more or less falling apart, and where managers are working to make sure that the chaos which results is not falling on their own heads. A storm of complexity confronts and confounds many managers, and organizational leaders, as they struggle to make meaning of the dynamic and apparently chaotic forces that have been let loose. There is frequently a concomitant lack of acknowledgement by organizational leaders of the fear and anxiety which people are experiencing as they work in an environment filled with uncertainty. In a situation such as this, success can be experienced by managers as "simply getting through the day". Furthermore, organizations often fail to recognize, acknowledge, and channel the resilience, loyalty and commitment to the organization of those who have survived the acute stage of the change. This was the case in the research here, where interviewees experienced many negative responses to the forced restructuring of their hospitals, and the many changes to their work practices that followed. Responses such as these have been identified as survivor syndrome, or, survivor sickness (Noer, 1993).

Researchers such as Young and Brown (1998), Ciancio (2000), and Valent (2001), addressed specifically the appearance of survivor symptoms as an outcome of downsizing in the health industry, or following hospital closures and amalgamations. In their studies

the trauma experienced by the remaining workforce mirrored the symptoms described by the participants in the present study, including distress, alienation, apathy, demoralization, irritability and decreased functioning. These symptoms have been defined in the literature as the negative effects of a downsizing, or a contraction, of staff. Brockner (1992) and his colleagues examined variables such as how the layoffs were implemented, survivor's perceptions of fairness of the dismissals, and survivors' identification with the dismissed workers. Variables such as these were also seen to impact significantly on the interviewees in this research.

Noer (1993), however, viewed layoffs as rather more than the simple result of downsizing following a restructure. To him, layoffs were symptomatic of something more fundamental – that is, they were an inevitable consequence of a fundamental paradigm shift in the world of work. That is, where in the past the assumed psychological contract between employee and employer involved the belief that the latter had an obligation to retain the former, in the new era of economic rationalization, restructure, and downsizing, the psychological bond supporting the employee-employer relationship was violated. Those who survived these changes felt personally trampled on, said Noer (1993), and these feelings directly related to the symptoms they exhibited post-changes. Thus it was for many of the interviewees in this research too.

In summary, the amalgamation at the heart of this research was a very hard process. People were in a state of shock, and even more shattered when they had to cope with the abrupt budget cuts and financial constraints which accompanied the amalgamation. Casemix, which was introduced to standardize the allocation of resources to hospitals, was

seen as a positive innovation in principle, however, largely unsuccessful in practice. Budget cuts ensured that the hospital campuses were stripped of beds (no pun intended), while no attention was paid to the maintenance of the basic infrastructure. People had to get used to new venues and new ways of working. They remained suspicious and hostile towards any changes in this area. As well, the implementation process employed in this amalgamation had political overtones, and was perceived to smack of payback. The process was perceived to have been handled ineptly by Health Department officials, who were seen as having personal agendas. There were winners and losers in the fight for new positions in the restructuring. The ultimate losers, the interviewees have said, were the patients who, it was felt, were sent home too early and without the same quality of care they had received pre-amalgamation.

Although it was ultimately something that did not happen, the future of the newly amalgamated Alpha and Beta Hospitals (Delta Medical Centre) was widely seen to be one of privatization. It was therefore seen as a good time to leave. A lot of experience and talent therefore moved on, as staff "jumped ship" or were forced out. Those who stayed were angry, anxious, fearful, depressed and demoralized. There were problems trying to achieve a unity between two sets of personnel belonging to previously independent institutions, with diverse values, visions, and organizational missions, and therefore very different cultures. Although the survivors were expected to carry on regardless, covering for the loss of others while increasing productivity and aiding the organization to become more competitive, when the same interviewees were approached about a year later, they were still grappling with much the same issues. People were still sad and risk-averse. Over time, many seemed not to have come to terms with the changes. To make matters

worse, many of the interviewees had been able to compare this amalgamation with an earlier one, where their experiences were more positive, and harm minimization was seen to be the most important consideration. This earlier experience, then, made the later amalgamation all the more hurtful and difficult to comprehend, and to adjust to. Even though it was admitted that change was necessary to overcome certain wasteful and economically unviable aspects of hospital administration and management, the manner in which the changes were implemented so debilitated hospital staff that productivity and morale remained low even after 12 months, and more, had passed.

SOME LESSONS LEARNED

Whenever a sudden and dramatic shift in Government philosophy and policy forces an immense change that affects the lives of ordinary people in profound and often disturbing ways, great care must be taken to minimize the negative effects which inevitably ensue for the workforce caught up in the storm of change. As Bright (2000) noted, when change management initiatives are activated in Australia, these usually begin with structure, and end with staffing levels. Arguably there is nothing in between, and this becomes a certain recipe for survivor symptoms.

Literature has shown provision of ample support and protection for staff is the key to an organization's recovery and growth following structural change. One way to provide such support and protection is, as contended by Davis (2003), an implementation plan that is in place early. Long-term and structured planning help to maintain staff morale. Advance knowledge of pending layoffs need not necessarily adversely affect productivity or morale. If support, such as help to write a Curriculum Vitae and to source a new job, counselling, financial advice, and so on, is provided for those staff who will no longer have positions in the restructured organization, then surviving staff will be more likely to retain their trust in management and the amalgamation process. It is also important, moreover, to address the fears and concerns of the remaining workforce so that they do not feel guilty because they have retained their jobs (Davis, 2003). Interestingly, as with Noer's (1993) sample, no participants in the present study expressed guilt about retaining their jobs. Any concern was, instead, about maintaining the status quo. Re-establishing and maintaining trust and

loyalty, and improving morale, are all vital aspects requiring attention in the lead-up to, implementation of, and following, organizational change. As we have learned from the present study, however, improving the morale and the future prospects of remaining staff, as well as the prospects of their patients/clients, is not assisted when structural change is accompanied by repressive policies, such as the implementation of budget cuts and other financial constraints.

Arguably, people moving through change benefit from an approach which treats change as a process, rather than as an event, and one which is responsive to the concerns of people as they are struggling to adapt to the changes that are taking place. If change is to be achieved effectively and sustainably, however, it requires preparation, time, and resources. As the interview narratives demonstrate, initially there is a need to assess the individual responses of those people involved in the change initiative: are they excited, scared, threatened, committed, unaware, needing more information, or ready to become actively involved? People have different levels of receptiveness to the change process, and this needs to be acknowledged and dealt with, through deliberate, and transparent, policies and practices. People will have difficulty accepting change if their personal issues are not addressed. Many will need assistance with grieving for "what was", and planning for "what will be". Support staff, often in the form of counsellors, may be needed to reassure people and relieve anxiety. The participants in the present study, for instance, were singularly unimpressed with the level and amount of counselling provided to assist people through the process of amalgamation. As a consequence, people became frozen in their responses and unable to move through the grieving process.

Change is a complex, multi-dimensional activity, and hospital managers are no less prone to being stressed by it than those above and below them. In spite of the need for the amalgamated Alpha - Beta hospital in this case study to accommodate new administrative and financial agendas, its managers found themselves being squeezed between upper management demanding results, and employees demanding organizational justice. These pressures then interfered with their ability to make effective decisions. Instead of the expected performance improvements, negative feelings and behaviours, at all levels of the organization, were re-inforced, and morale and productivity suffered. Research has shown that hospital managers need to recognize the suffering going on around them, and the often entrenched denial of their own, and others, feelings. Although there is a strong emphasis in the literature on survivor sickness that it is complicated and that there is no quick fix, hospital managers need to admit that survivor symptoms are real, and that they and their organization have become susceptible to it. When looking for ways to deal with the problem of survivor sickness, it is important, however, to remember that what works for people in one change situation dealing with one particular set of organizational parameters, may not necessarily transfer to another. Implementation of a universal solution to a unique situation, where people are attempting to deal with the chaos of organizational change, is no guarantee that the anxiety will abate.

Research has noted, however, that by working towards open communication and showing compassion for their staff, managers can help both themselves and their employees accept change and move forwards (Ciancio, 2000). Indeed, the narratives presented in this thesis suggest that communication is one hallmark activity in achieving effective change management practice. Bright's (2000) research suggested that when an amalgamation

occurs which involves a group larger than five hundred individuals, a massive communication and change management process will, by necessity, be required in order to sustain pre-merger performance levels. Effective communication can best be achieved via a variety of venues and formats including open meetings, educational forums, open staff meetings with administration, work-team meetings, newsletters, a rumour hotline, and so forth. It would appear that no matter how much you do, you cannot communicate too much. Ironically, though, communication often decreases, rather than increases, during the early stages of organizational change. Moreover, open communication depends on the visibility and access of senior administrative staff. Communication is a two-way process at all levels, and in the present research, the participants themselves suggested procedures which might have been helpful in this regard, such as scheduled meetings that allowed for open discussion and venting of feelings; and the opportunity for managers and employees alike to express the full range of their emotions, including any "craziness" that people felt. In other words, to help employees adapt to the changing realities of the workplace, their emotional upheaval and discontent must be acknowledged.

Where a major change also involves the bringing together of two, disparate cultures, as was the case in the amalgamation here, the problems and difficulties are compounded. The narratives of interviewees in this research confirmed the literature that notes that people often take their company cultures for granted, until a merger, or other change, creates the fear that certain aspects of their work life will be lost (Mirvis & Marks, 1992). Such fears also lead people to defend their own culture and attack the other, which was evident in the case in point. Leaders and managers of new work units need to establish new work practices with new combinations of staff, however, this is complicated by the clash of

cultures. Identifying, and openly recognizing cultural differences can therefore be seen to be just as important as recognizing the symptoms of survivor syndrome. In the research here, however, not only was there a failure to celebrate the histories, styles, and reputations of the Alpha and Beta Hospitals as separate organizations, but there was a failure to provide opportunities for people to grieve for what they were to lose.

Often overlooked in the practice of managing change is the importance of the language used by all those involved in the change process. Language is the medium through which the story of change is told. Language helps organizations, and the individuals in them, to make sense of the change event. The metaphors encapsulated in the language used to describe the reality of the change event create and guide the thoughts, feelings, and behaviours of the participants. Thus, the use of the phrase here, for example, of "survivor syndrome" would have special resonance for health professionals and administrators who feel they are working in a "sick system" requiring healing. The metaphor thus provides a vivid short-hand way to describe a system and situation of high complexity and ambiguity.

Language and metaphor, however, are not only useful in understanding a past or present reality. It is suggested here that as metaphors are powerful, symbolic, communicative vehicles for the change effort, the deliberate use of a new metaphor, in this case "physician heal thyself", may have helped open up strategic options for a brighter, more helpful future. Unfortunately, no attempt was made, in the case here, to commence the development of a new narrative, with the newly amalgamated hospital at its centre. This is not at all unusual when organizations amalgamate, or merge, because it is assumed that the key strengths of the merging institutions will come to the fore. This was the fiction fed to the interviewees

in the present study, who were told that they would be alright because "they were not losing their jobs, they were just amalgamating" (the Interviews). Unfortunately, as in the case of this amalgamation, the reverse is often the case: key strengths do not come to the fore, and people are not alright. More often than not, people become confused and lose their way. They are left stranded because the old familiar vision and direction are no longer the same. These have been subtly, but irrevocably, changed forever.

There may be a new direction or vision, but what does it mean? It may be very clear to those who wrote it (in this instance, the State Government), but to those who must follow it, there are no connections, no markers, no way of telling where the journey will lead them. It should be noted that at the time of the follow-up interviews the path forward for the Delta Medical Centre was still unclear. Much has happened since then, of course, but a detailed analysis of those subsequent events is outside the scope of this thesis. This thesis presents a particular slice of history in the provision of health services in Australia, and the State of Victoria. It is part of an on-going story. A thesis, however, must have an end. This author has chosen to end in 1999, with the follow-up interviews.

RECAPITULATION

This thesis has been broadly concerned with the shift, in Australian Commonwealth and State health care discourse, from a philosophy of universal coverage and free care, to economic rationalism and the freedom of individuals to decide whether, and where, to spend their money on medical services. Government has remonstrated that separation of policy decision-making from service delivery functions, the institution of contractualism and corporate management models in hospitals, and a forced free market will result in efficiencies in the health system, long overdue.

Following the lead of the Australian Government, the Victorian Liberal-National Government of the early nineteen-nineties pursued a policy of public expenditure reduction, rationalization of services, case-mix funding, increased managerialism in the senior ranks of the public service, and an emphasis on service-delivery and user payment. These strategies, combined with a policy of amalgamation of hospitals, caused major disruption within the health system generally, and in the affected hospitals specifically.

Until recently, very little research has been conducted into the effects of change management on public hospital employees in the Australian context. Writers such as Valent (2001) are a rare exception. With this in mind it was decided to research the single case-study of a particular, forced amalgamation, of two culturally, very diverse hospitals.

Needless to say, the amalgamation was a huge change for the staff of both hospitals, and it had a profound, and lasting effect on the individuals concerned. The narratives of the individuals interviewed here have given a deeply personal, vivid picture of their lived experience of the change process.

A number of lessons may be learned from their experiences. These include the need to draw up an implementation plan that sets the framework and timetable for the changes; the offer of appropriate support systems for those who are to leave the organization, and importantly, for those who are to stay; communication of all details of the change, often and in a timely manner; honesty about what is happening and why; a genuine effort by senior management to acknowledge and share with others their own difficulties and pain; assistance with the grieving process, on an organizational as well as an individual level; and an authentic search for an enabling metaphor to symbolize the hoped for better future.

It is clear from the accounts of the interviewees here that great care must be taken in the face of such fundamental changes, to minimize the negative effects which ensue, in order to reduce any debilitation of hospital staff and the resultant loss of morale and productivity. Arguably, if changes had been handled more sensitively, health providers and the hospitals they worked in may have adjusted more easily and been able to provide the individual consumer with the efficient, cost effective service that governments intended. Undeniably, the health system in Victoria endured a huge change that proved difficult to administer. It unquestionably, could have been managed better.

GLOSSARY

Broadbanding

Part of the public health reform process in the mid-1990s. Refers to the pooling of specifically allocated program dollars into one block grant. The aim of this reform was to create greater flexibility and administrative efficiency in Commonwealth-State financing arrangements in public health.

Casemix

In Victoria, the introduction of casemix funding in 1993 meant a shift from input budgets to output-based funding and represented an innovation in funding arrangements for hospitals. Casemix funding changed the perception that hospitals owned their budget; funds were seen as public (Government) funds, and hospitals were paid according to what they produced. The 1993 arrangements saw the introduction of a funding formula. Each hospital could develop its own budget according to its own forecast of the number of patients it would treat. Casemix funding meant that once patients had been classified into Diagnostic Related Groups (DRGs), a standard price could be assigned to each DRG and hospitals paid on the basis of how many patients in each DRG the hospital treated.

Clinical Service Units (CSU)

Clinical service units refers to the establishment of self-managed units of like services within the Delta Medical Centre. The Cancer Services Unit encompasses Oncology, Haematology, Radiotherapy. Palliative Care, and Breast Surgery. Neurosciences covers Neurology, Neurosurgery, and Ophthalmology. Each unit is organized like a small business unit with its own Director and Manager. The Director, usually a senior clinician, is ultimately responsible for the success or failure of the CSU. The Manager is responsible for running day-to-day activities.

Co-Location

A process whereby public hospitals responded to the rise of private hospitals and their own need to harness capital and reduce infrastructure costs, by introducing the co-location of private hospitals on the campuses of public hospitals.

Council of Australian Governments (COAG)

Refers to the work of the Council of Australian Governments (COAG) to establish a wide-ranging reform agenda focused on improving the efficiency and effectiveness of service delivery by restructuring the planning, organization and funding relationships between Commonwealth and State governments for health and community services. By 1994, COAG had proposed that health reform be constructed around three major streams: acute care, general care, and co-ordinated care.

Diagnostic Related Group (DRG)

DRG refers to the way by which hospital activity can be described. Because of their design characteristics, in particular because patients in the same DRG are expected to consume similar amounts of resources, DRGs were able to be used to standardise for differences in the casemix of hospitals, and thus allow comparisons of hospital efficiency. With the election of a Liberal Coalition Government in Victoria in October 1992, the DRG was transformed from being simply a method of describing hospital activity and comparing hospital performance, to a way of funding hospitals.

Discourse

Refers to the representation or articulation of certain knowledge(s) as truths.

Dominant Discourse

Refers to the way in which complex political ideas and traditions are selectively incorporated to bring together different elements for the purpose of combining them in a new identity.

Downsizing

Also referred to as Layoffs. Refers to workforce reduction, usually as an outcome of cost-cutting measures or where a merger or acquisition is associated with organizational restructuring.

Economic Rationalism

The dogma which says that markets and money can always do things better than governments, bureaucracies and the law. Economic rationalists believe that the central aim of policy should be the establishment of a framework in which the efficacy of market forces is maximized, and hence where resources can be allocated as efficiently as possible. Policies should concentrate on improving the dissemination of information, improving the mobility of labour and other resources, discouraging restrictive practices, and trying to encourage as competitive a system as possible.

Free Care

Provision of free medical services in public hospitals.

Global Budgets

Describes the new output orientation of health service agreements commencing in the mid-1980s. Funding was provided to Victorian hospitals in a single broad category or global budget. Hospitals had autonomy to shift funds between various classes of inputs (including different personnel categories), and between salary and non-salary expenditure. Global budgets were seen by Government as a key method for improving hospital efficiency at this time.

Health Maintenance Organization (HMO)

Refers to institutions that organize and manage some health care to their customers while contacting for the rest. These institutions may also provide both primary and secondary care to their clients within their own facilities with salaried staff.

Health Service Agreements

In the mid-1980s, detailed input control for hospital funding in Victoria was replaced by agreements which provided more autonomy to hospitals, and which replaced detailed input control with broad specification of expectations of hospitals in terms of the number of patients treated.

Hospital Boards

Historically, each hospital had its own Board. Before the establishment of networks, guidelines covering the roles and responsibilities of hospital Boards were spelled out by the Health Services Act 1988. Under this legislation, the Board of a public hospital was a Board of Management. With the advent of networks, a leaner, tighter structure was proposed. Hospital Boards under these new arrangements were seen as more akin to Boards of Governance.

Human Capital

The stock of acquired talents, skills and knowledge which can enhance a worker's earning power in the market. It is argued by human capital theorists that wage differentials are the reward for the personal investments individuals make in their human capital, that is, the investment in education and training that individuals choose to undertake beyond their compulsory school years.

Input Control

Refers to the method by which Victorian hospitals were funded prior to the 1980s. Hospitals were subject to detailed input controls, including specification of the number and type of staff to be employed, and detailed specification of various categories of non-salaried expenditure, such as pharmaceuticals.

Market Value

A concept embraced by economic rationalism which assumes that given the efficient allocation of resources throughout society, people, or organizations, will be differentially rewarded according to their ability to advance the goal of economic productivity.

Medicare

1984 – Australia’s first compulsory and universal health insurance scheme, designed to ensure universal access to basic hospital and medical care.

National Health Service (NHS)

The National Health Service which was created in 1948, refers to the publicly-funded health care system of the United Kingdom. The organization provides the majority of health care in the UK, from general practitioners to Accident and Emergency Departments, long-term health care and dentistry. Prior to 1991, a feature of the NHS was that not only did it provide universal and free health care regardless of income, but it also employed the doctors and nurses, and ran hospitals and clinics. In 1991, the Thatcher Government introduced reforms that radically altered the internal organization of the NHS and the provision of services.

National Public Health Partnership (NPHP)

Refers to the multilateral partnership between the Commonwealth and all States/Territories to provide a mechanism for greater cooperation and coordination between jurisdictions on public health policy and practice.

Neoliberalism

Neoliberalism [also referred to as neoclassicism] is a philosophy in which the existence and operation of a market are valued in themselves, separately from any previous relationship with the production of goods and services, and without any attempt to justify them in terms of their effect on the production of goods and services; and where the operation of a market or market-like structure is seen as an ethic in itself, capable of acting as a guide for all human action, and substituting for all previously existing ethical beliefs.

Networks

The Interim Report of the Metropolitan Hospitals Planning Board (1995) recommended that hospitals be aggregated into a network under a single Board. In Victoria, the metropolitan hospitals were organized into units called “networks”. The vision for a substantially re-formed health care system included the creation of health care networks by incorporating tertiary acute hospitals, community acute hospitals and aged care services. The integration of services took place in sub-regional geographical areas servicing a common community.

Paradigm

The totality of thoughts, perceptions, and values that forms a particular vision of reality, a vision that is the basis of the way society organizes itself.

Pharmaceutical Benefits Scheme (PBS)

The Pharmaceutical Benefits Scheme (PBS) ensures that all Australians have access to affordable medicines as prescribed by medical practitioners. Those on low incomes who are eligible for health-care cards, have access to drugs listed on the PBS for a relatively modest patient contribution. Prescriptions become free for concessional users once they incur the cost of the equivalent of 52 patient contributions. Pensioners are provided with a yearly pharmaceuticals allowance equivalent to the cost of the safety net. General users (those without health care cards) are required to make a larger patient contribution, and the safety net is less generous.

Preferred Provider Organization

Refers to organizations that primarily coordinate private, solo practices and medical institutions on behalf of their clients, but still leave individuals a wide range of choice for extra, direct out-of-pocket or insurance pay.

Psychological Contract

The implicit agreement between employer and employee in the workplace by which an employee assumes that he or she can expect conditions such as trust, job security, opportunities for promotion, loyalty, fair treatment, respect, and appreciation for good work undertaken. The contract gives workers psychological control over their work environment, which lets them freely invest themselves in performing their role.

Public Health Outcome Funding Agreement (PHOFA)

In the 1997/98 financial year, the first Public Health Outcome Funding Agreements (PHOFA) were signed between the Commonwealth and the States. Essentially, the agreements transferred the the pool of public health funds to each State via one funding agreement. States agreed to be accountable against a set of outcome indicators.

Rational or Social Choice Theory

The assumption that humans are motivated in their political and economic behaviour to maximize self-gain. Perceived as a liberal economic unit, the individual is unitary, calculating, egoistic, motivated solely by the economic end of accumulating wealth by means of profit maximization.

Specific Purpose Payments (SPP)

Refers to the “broadbanding” of specific purpose payments (SPP) for the transfer of public health funding from the Commonwealth to the States/Territories into bilateral Public Health Outcome Funding Agreements (PHOFA). SPPs emerged in the 1970s and continued into the early 1990s.

Survivor Sickness

The human cost of downsizing. A debilitating process which affects those people who stay on in a restructured organization. The effects on survivors include anxiety, distress, alienation, apathy; demoralization expressed in terms of increased sickness, inability to sleep, poor concentration, increased absenteeism and intolerance, all leading to decreased productivity.

Tertiary Hospitals

Refers to those hospitals offering inpatient services requiring twenty-four hour access to highly specialized medical, nursing and allied health staff, expensive infrastructure and a comprehensive range of investigations.

Text

Text refers to the words or the subject matter which forms the content of the spoken or written narrative.

Universal Coverage

Universal and compulsory, taxation-based health insurance.

Victorian Hospitals Association (VHA)

The industrial body which represented the leadership for public hospitals in Victoria and which traditionally supported the maintenance of substantial autonomy for the hospitals. In 1993, when the Liberal Coalition Government took control in the State of Victoria, the VHA supported the introduction of casemix funding against a background of increasing concern about relative hospital costs.

Voluntary Departure Package (VDP)

Refers to the agreement between employers and employees to award compensation to an employee who loses their job through no fault of their own. A typical agreement is awarded in terms of severance pay which is generally based on length of service.

World Health Organization (WHO)

The World Health Organization is the United Nations specialized agency for health. It was established on 7 April 1948. World Health Organization's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health.

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