Managing Interorganisational Relationships:  
An In-depth Study in a Hospital Context

By

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ABSTRACT

Can interorganisational relationships be managed for effective functioning? This is the problem investigated in this research. Organisations world-wide are adopting co-operative relationships with other organisations. These interorganisational relationships are viewed as a way to enhance their own business performance (Williamson 1985, 1991; Dyer 1997; Gulati 1998; Barringer & Harrison 2000; Das & Teng 2000; Quinn 2000; Stuart 2000; Johnson, Korsgaard & Sapienza 2002). Despite this, the success rate for interorganisational relationships is not high (Hutt, Stafford, Walker & Reingen 2000; Quinn 2000; Hitt, Ireland & Vaidyanath 2002) with many of them failing to achieve their objectives. Understanding how to manage these boundary-spanning arrangements is important to realising the objectives of the business strategy.

The research setting is a large private hospital in Australia. It works with a network of external service organisations that provide the Hospital with a range of clinical and non-clinical support services including: Diagnostic Imaging, Pathology Pharmacy, Food Services, Environmental Services, and Human Resources support. This research explores how these different relationships were managed in their operating period: 1998 to 2002. It reveals the dynamic and often ad hoc way, in which managers made sense of the collaborative service context, and how managers influenced the process of interorganisational relationship formation.

Extant research about interorganisational relationships comes from a variety of fields. For this research it is most relevant to draw from the research fields of organisational theory, organisation behaviour, sociology, psychology and management. These fields contribute findings that provide useful knowledge upon which to build further understanding about how managers contribute to construct interorganisational relationships functioning (Ring & Van de Ven 1992, 1994; Walsh 1995; Chikudate 1999a, 1999b; Boddy, Macbeth & Wagner 2000; Hutt, Stafford, Walker & Reingen 2000; Lasker, Weiss & Miller 2001).
This research uses an interpretivist methodology that enables the researcher to explore the dynamic nature of the Manager’s sense-making in the construction of six interorganisational relationships. For the purposes of this research, interorganisational relationships are defined as new structures that emerge through the social interaction of actors involved in shared service delivery. The collaborative context of interorganisational relationships stimulates managers’ sense-making by challenging institutionalised ways of behaving. This sense-making process builds new knowledge stores and contributes to emerging, new management routines. The process is transformative and enables the emergence of interorganisational relationships.

It emerges from this research that managers take cues from their context. These cues are used to interpret and make assessments that enable decisions about those actions that they take to construct the interorganisational relationships. A manager’s processing of contextual cues, through interpretive frames and dispositional sense-making filters, is an inter-subjective, socially constructive process. The ‘self’ is a dimensional influence in the managers’ sense-making and management behaviours and is implicated through the notion of contextual interpretive frames and dispositional sense-making filters. A model of interorganisational relationship management as a transformational process is developed. The association between contextual influences and managers’ behaviours will raise awareness for professional practitioners of the challenges involved in managing across organisational boundaries and in turn, may contribute to more successful implementation of interorganisational business relationships.
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Thank you all.
DECLARATION BY CANDIDATE

This thesis contains no material which has been accepted for the award of any other degree or diploma, except where due reference is made in the text of the thesis. To the best of my knowledge, this thesis contains no material previously published or written by another person except where due reference is made in the text of the thesis.

Signed: ___________________________

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1 INTRODUCTION

1.1 Introduction

Relationships between organisations are good for business but like all relationships, they require to be nurtured. Interorganisational relationships are complex collaborative processes that form when two or more organisations co-operate for business. Responsibility to create these new dyadic organisational arrangements usually falls to managers and it can be challenging work.

Alvesson (2003) identified auto-ethnography as developing from the researcher’s active participation and observation of phenomena over an extended period of time. This dissertation has emerged from five years of exploration during which time the researcher was the Manager of interorganisational relationships in a large private hospital in Australia. To retain confidentiality this hospital is referred to as the ‘Hospital’ throughout the dissertation. The six interorganisational relationships delivered diagnostic imaging services, pathology services, pharmacy services, food services, environmental services, and human resources advisory services. Each of these interorganisational relationships was established when the researcher commenced at the Hospital.

This chapter provides the background to, and justification of, the research. Section 1.2 provides background to the interorganisational relationships in which the Hospital was engaged. A statement of the research problem and the research questions follows in Section 1.3. There is an explanation of key terminology used throughout the dissertation in Section 1.4. This is followed by a statement of the purpose of the research in Section 1.5 and an overview of the research strategy including the research context in Section 1.6. The contribution of the research is outlined in Section 1.7 and the structure of the dissertation is described in Section 1.8. The chapter finishes with a summary in Section 1.9.

1.2 Background to the Problem

The formation of interorganisational relationships is a world-wide phenomenon. An Australian Workplace Industrial Relations Survey conducted by the Federal
Department of Industrial Relations in Australia in 1990, and again in 1995, suggested that the majority of workplaces in five industry sectors had contracted out services during the previous six years. This extends the international trend also underway in the health sector to create and strengthen networks of primary community health services, and to manage relationships between community health services and acute hospital services. Research by Zappala (2000) suggested that in the health and community services sector 22.4% of the workplaces had contracted services.

During the 1990s the Australian public sector divested more than US$37 billion worth of public assets up until 1998 (Hodge 2000). It has been estimated that US financial institutions were planning to relocate more than 500,000 jobs to offshore processing centres by 2009 (Corporate Outsourcing 2004). Further, Deloitte Research estimated that Western Europe would offshore 730,000 financial services/information technology jobs by 2008 and Japan 400,000 jobs. HSBA, one of United Kingdom’s largest banks, already has moved 4,000 jobs to China, Malaysia and India (Gentle 2003).

This adoption of an interorganisational relationship approach has contributed to the growth of organisations whose sole activity is the provision of particular services to other organisations. The Hospital, in which this research was conducted, adopted an interorganisational relationships strategy more than twenty years ago. Of the many hundreds of relationships it has formed, the critical ones are those with specialist medical and surgical consultants across a range of specialties, to provide acute clinical services to patients. Without clinical consultants there would be no patients for the Hospital and without patients the Hospital would not be in business. The Hospital also has six other significant interorganisational relationships with providers of near-core clinical support services and peripheral non-clinical support services.

Interorganisational relationships have enabled the Hospital to focus its resources on core nursing capabilities and to also gain access to high cost technologies, resources such as intellectual property, innovative service delivery systems and cost efficiencies in service delivery processes.
The researcher (as the Manager) was responsible for managing the interorganisational relationships with the external service providers of diagnostic imaging services, pathology services, pharmacy services, food services, environmental services, and human resources. Managing these interorganisational relationships was a social process through which she interpreted, and made sense of, her relational context so that she could take decisions that would achieve the Hospital’s objectives and her responsibilities within these. ‘Sense-making’ powerfully affects what happens in organisations. The following vignette, from the Hospital setting, is constructed to illuminate the situation of a nurse working within a context where near-core clinical support services are outsourced:

*When nurses care for patients they expect to find they have a patient and a care path that they are responsible for. Experience tells them they will share this patient with a doctor and that they will have other team members of specialists to call on. If in doubt call a charge nurse. They are all part of the Hospital team. They know the ropes and how things work. When the Hospital decides to outsource several parts of the services in the care path the systems are not quite the same as they were. The nurse tries to rationalise the shift in her situation. She feels less “in control”. Who is this other organisation? How will they know my needs and my patient’s needs? Who do I contact? When will they come? The patient’s need is increasing. Why does the external provider not see that the needs are urgent? Why does the other person question this urgency? The young nurse can no longer manage the care service with the same pattern of meaning. A falter or a delay occurs because sense-making has become deficient. The context has changed. She needs to construct a new social reality. This can be a hard if nurses around her have different patients with different needs at the time. They do not share the same sense of reality as the young nurse, because they are constructing another reality based on their own experiences and their patient’s immediate needs.*

Initially, the Manager found it difficult to know how to assume her responsibilities for, and within, these interorganisational relationships. The hand-over provided by her predecessor was brief and focussed on the food and environmental services. These services were delivered by the same external provider and there seemed to be challenges in the relationship. The human resources function was devolved to line managers and the external provider had an advisory role to support the line
managers as required. The diagnostic imaging, pathology and pharmacy providers all seemed ‘to do their own thing’. Nurse Managers looked to the Manager for leadership and support with these external providers who assumed responsibility for clinical support services that were integral to their patients’ care paths. The previous Manager met with these providers at a joint monthly meeting to discuss operational issues. Apart from this, the Manager perceived that there was little apparent governance of the interorganisational relationships.

Each of the external service providers had established relationships with the Hospital which extended back many years. In the case of Human Resources services, the external provider was engaged in 1995, after the Hospital restructured its human resources function and formed the ‘spin off’ organisation. There were no guidelines to describe what was expected of the service relationships. The near-core clinical support providers each had long term leases comprised of several renewal options. The food and environmental services provider had a contract that was six years old, but this was not associated with any scope of services that she could find. Governance of the human resources advisory services was relatively informal. For instance, in 1998 when the interorganisational relationship was due for renewal, the Manager identified a four page letter on file that summarised the provider’s services when it was initially engaged by the Hospital.

The Chief Executive articulated to the Manager that partnership longevity with the service providers was desirable and that reliance on the expertise of external providers would provide quality services. In the past, if ever a problem or an opportunity to deepen the relationships arose, then there would be discussions or direct negotiations to work through the issues in a non-confrontational way.

At the patient interface, nurses and clinicians viewed the Manager as a point of contact to whom issues could be escalated if they could not be resolved at the work place level. Patient and staff complaints about the outsourced services were referred to the external; providers via the Manager, as were issues regarding the scope of services. She tried to negotiate and resolve issues through discussions. In the food and environmental services the Manager retained responsibility for these employees and she felt the need for greater involvement with issues that arose.
The Manager commenced a process to develop service agreements for each of the interorganisational relationships. These steps were passively resisted by some of the providers. In time, however, this began to change. Significant events occurred to cause some senior Hospital executives to reflect on their approach to governance of the ‘outsourced services’. One such instance occurred when there was a change of ownership with respect to one of the near-core clinical support providers. As a result, the business was transferred to a significant Hospital competitor organisation and it commenced to operate within the Hospital’s own premises because the existing leases transferred to the new owner. Another event occurred when the Hospital attempted to renegotiate an existing supply agreement with the pharmacy provider. On this occasion the Hospital experienced strong resistance from the provider when the Hospital decided, due to escalating costs for pharmaceuticals, that it wanted more means to control the rising expenditure. Similarly, when staff and patients’ complaints about the food services rose, and when the Manager’s financial analysis showed that the Hospital was possibly paying too much for the services received, the Executive managers began to reflect on how they could manage these interorganisational relationships to give the Hospital some more ‘control’. The ‘outsourced services’ then began to receive more attention at the executive level. Upon reflection some Executive managers perceived there may have been some lack of attention to the formal governance and structure of the interorganisational relationships. It was discovered they had little leverage to make change to long standing leases and established practices. As the Hospital’s business environment changed, some of the interorganisational relationships came under closer scrutiny. For the Manager, a sense developed that some of the interorganisational relationships needed to adapt to meet changing Hospital’s expectations and requirements.

The Manager was very involved in the daily operations of the food, environmental and human resources interorganisational relationships. In so doing she adopted multiple roles. She became a contract manager, a relationship builder, as well as line manager with accountability for outcomes. Problems, criticisms and issues became hers. Employees, patients, clinicians, nurses and Board members expressed their dissatisfaction and observations to her on a regular basis. There
was a period when she felt overwhelmed by her personal sense of responsibility for the Hospital community’s complaints with the ‘outsourced services’. She struggled with her reflections about how to manage collaboratively, particularly as she perceived that other Hospital managers wanted more leadership and control of the services delivered through the interorganisational relationships. They looked to her to make sense of this collaborative context.

The Manager regularly reflected on why it seemed so hard to manage these interorganisational relationships. She discussed her perceptions and her interpretations with professional colleagues. This research has extended the Manager’s reflective process. This reflexive interpretation of interorganisational relationship management contributes to existing research about interorganisational relationships, most particularly because of its interpretive methodology and its focus on the social, sense-making processes of managers in the field. It also extends studies about the not-for-profit service industry sector. Little investigation has been undertaken, at the organisation level, in this sector and about a business strategy that has, apart from public sector privatisation, traditionally been associated with the for-profit sector.

1.3 Statement of the Problem

Can interorganisational relationships be managed for effective functioning? This is the research problem that gives rise to the following questions:

How are interorganisational relationships managed at the Hospital?

How does management activity differ between interorganisational relationships at the Hospital?

What makes the management of one interorganisational relationship differ from that of another at the Hospital?
The Hospital provides the setting for an illuminative investigation of the sense-making process of a senior client manager as she managed the formation of six interorganisational relationships in a hospital.

1.4 Definition of the Terms Used in the Research

The following definitions relate to the terms used frequently throughout the research.

1.4.1 Interorganisational Relationship

The interorganisational relationship is the context for this research. One accepted definition of an interorganisational relationship is presented by Ring and Van de Ven (1992, p. 5) who described interorganisational relationships as ‘socially contrived mechanisms for collective action, which are continually shaped and restructured by actions and symbolic interpretations of the parties involved’. Ring and Van de Ven’s work emerged from research in the financial and collective bargaining field and their view of the concept embodies a somewhat transitory or ephemeral dimension. Their formulation of organisation as a dynamic process carries the context of interorganisational relationship beyond physical ‘reality’ and enables the phenomenon of interorganisational relationship management processes to become the focus of this research.

The interorganisational relationship context of this research is located within the broader setting of a large not-for-profit private hospital. The Hospital partnered with other organisations for the provision of near-core clinical support, and peripheral non-clinical support services to patients and staff.

1.4.2 Functioning Interorganisational Relationship

Functioning interorganisational relationship refers to the interorganisational relationship process in which the different perspectives, orientations, knowledge stores and practices of its members in a collaborative process which results in a synergy and a momentum to meet the objectives of the relationship. Lasker et al. (2001) propose that synergy is the outcome of relationship functioning.
1.4.3 **Management Activity**

Management activity refers to an explicit and observable action by a manager within the context of an interorganisational relationship. This is the reflex interaction (Cunliffe 2002) that represents manager’s explicit sense-making about a context and may include for example, a meeting, a discussion, a negotiation, for example.

1.4.4 **Not-for-profit Organisations**

Not-for-profit organisations have traditionally been associated with social or community goals. Uncertain funding arrangements, characterised by the never-ending search for benefactors, grants and bequests, have been associated with this sector.

The not-for-profit sector evolved a culture to reflect a stronger benevolent focus on social and community projects. Accountability may be to a Board of Directors, just as with for-profit organisations, but the same shareholder accountability is absent. The use of market driven, competitive metrics for performance measurement has evolved more slowly in the not-for-profit sector organisations (Hubbard 1997) although this is changing. Annual reports for such not-for-profit organisations are generally harder to find in the public domain. However, at the Hospital which provides the context for this research, the concepts of ‘margin’, return on earnings, cost structures, inpatient throughput per bed day, productive labour hours per bed day, all comprise metrics used for reporting at Executive and Hospital Board levels.

Not-for-profit organisations often have strong fiscal accountability to donors, patrons and other funding bodies. In addition community sanctions may be just as strong as those that exist for ‘for-profit’ organisations. The number of recent ‘for-profit’ health organisation mergers (Table 1-1) is testimony to the pressures for accountability that apply to organisations in both sectors.
The Hospital in this research is an exception to the small community based organisation. Its size and role make it comparable with many for-profit organisations and other publicly funded organisations that exist to support broad community goals. The Hospital operates in most respects like a for-profit business but enjoys differential taxing arrangements that enable profits to be reinvested in its own operation. It has a Board of Directors and is required to be registered and report activity to government.

1.4.5 Service Provider

A service provider is an external organisation that provides services to the Hospital. An external service provider may support, or provide in full, a service that the Hospital requires, such as food delivery, cleaning and pharmacy services. The service providers presented in this dissertation have not been identified for reasons of confidentiality and anonymity.

1.4.6 The Client Organisation and the Hospital

The client organisation is the purchaser of services delivered to it by external organisations. In this research, the Hospital is the client organisation. The Hospital is a large private not-for-profit organisation with a Christian heritage. The six interorganisational relationships studied at the Hospital provide the context for the research. The perspective taken in this research is that of the Hospital, as client and as represented by the Manager.

1.4.7 The Manager

In this research the Manager was the Hospital’s employee. As mentioned previously, the Manager was also the researcher. The Manager was responsible for ‘outsourced services’ at the Hospital.

1.4.8 Core Business Activity

An organisation’s core business activity is critical to the organisation’s business viability and mission. In the past decade this has led many successful
organisations to ‘unbundle’ themselves into their component parts (Hagel & Singer 2000) and outsource those activities no longer considered integral to the business or transfer them to another organisation which can do it better.

The process of unbundling or business activity divestiture enables organisations to commit to their core processes. In the Hospital, nursing and medical care services represent core activities. All other activity is categorised as near-core, peripheral or non-core.

1.4.9 Near-core Clinical Support Services

In this research, near-core clinical support refers to activity that is related to the medical service paradigm. These services are provided to patients managed by nurses and on the authority of doctors. These clinical support services are near-core support activities that are close to the main competency of the organisation. They are activities that relate directly to the Hospital’s mission and are, therefore, strategically important. The Hospital’s core competence is medical and nursing care (Gilley & Rasheed 2000; Quinn 2000).

1.4.10 Peripheral Non-clinical Support Services

Peripheral non-clinical support services are those services that are distanced from the core competencies of the organisation. These services are delivered to employees of the organisation and support the broader functioning of the organisation’s activity. Some of these services may be delivered indirectly to patients through the authority of the nurses. Examples of peripheral non-clinical support services are food, cleaning, waste management and human resources. Peripheral refers to an activity that is less strategically important and further from the main competency of the organisation (Gilley & Rasheed 2000).

1.5 Significance of the Research

The research literature about interorganisational relationships suggests that the relational strategy is difficult and characterised by a high failure rate (Harrigan
1985; Chikudate 1999a, 1999b; Hutt et al. 2000; Quinn 2000; Hitt et al. 2002). Much of the research about interorganisational relationships has focused on understanding the reasons for the phenomena and with the performance of the strategy, at the dyadic level. Both empirical and conceptual analyses (Dyer 1997; Mockler 1997; Gulati & Singh 1998; Boddy et al. 2000; Hodge 2000; Stuart 2000; Lasker et al. 2001) have been undertaken and established that in most situations economic imperatives have driven decisions by organisations to adopt interorganisational relationships. The researcher agrees with the observation by Narayandas & Rangan (2004) that empirical research in relationship management has tended to take snapshots of relationships at given times and attempted to project trajectories for relationship outcomes. Few studies have specifically explored interorganisational relationships at the organisation level and the contribution that managers, and others, make to interorganisational relationships. This is a gap in the research to which this research responds. In this research interorganisational relationships have been conceptualised as organisation that emerges in the boundary spanning spaces between two or more existing organisations. This notion of interorganisational relationships enabled the researcher to explore managers’ sense-making activities during the process of forming these organisation structures.

Managers assume responsible guardianship for achieving their organisations objectives. They make decisions, direct, support and co-ordinate others to make work. Sense-making informs all this activity and sense-making is a dynamic and critical process through which managers make decisions that contribute to interorganisational relationship formation. Sense-making, and management, are processes underpinned by social interaction among diverse groups of stakeholders whose personal backgrounds and predispositions can affect the ways in which interorganisational relationships emerge over time.

This research adopts a longitudinal perspective, focused on exploring interorganisational relationship management processes. In so doing it is hoped to make a contribution that will advance professional practice for other managers of interorganisational relationships. The researcher used an auto-ethnographic field investigative method to explore, over time, the development of six
interorganisational relationships in a hospital context. The relationships were characterised by various structures and degrees of symmetry, and over the study period they evolved in dramatically different ways.

Much of the literature about interorganisational relationships is based in positivist conceptual frameworks. Such approaches rarely reveal the richness of the managers’ experience when they create functioning interorganisational relationships. While interorganisational relationships may be ‘the way to go’, this research reveals how complex and challenging the phenomena are to manage. The interpretive reflexive methodology has revealed the dynamic, complex and idiosyncratic social interplay between individuals and the interorganisational context to emerge.

1.6 Brief Overview of the Research Strategy

This research adopts a tripartite research strategy that is discussed in full in Chapter 3. The following sections provide a brief overview of the theoretical perspective, the research methodology and methods, and the research context.

1.6.1 Theoretical Perspective

An interpretivist perspective underpins the research strategy. This perspective holds that ‘reality’ is constructed from cognitive experiences and interpretations and that there is no single reality ‘out there’. In other words, ‘reality’ is seen as being multiple and socially constructed. The assumptions underlying this perspective are conducive to an exploration about managers’ sense-making activities in constructing interorganisational relationships.

1.6.2 Research Methodology and Methods

The research uses a interpretive methodology that grounds the researcher in the more informal, daily ways in which managers make sense of the collaborative management context created by interorganisational relationships. The researcher was immersed in the social world of organisation process, as an active participant
and observer, over an extended period of time. Richardson (2000) has referred to such investigations as ethnographies. The researcher’s reflexive interpretation of her experience makes this dissertation an auto-ethnography. Auto-ethnography can be risky business because the researcher may be ‘exposed’ by virtue of her own confessions (Van Maanen 1990), or reflections and interpretations about her experiences. This dissertation is a very personal account of the researcher’s interpretation of her social world during the research period.

The researcher adopted a client perspective of the management process during the construction phase of interorganisational relationship implementation. The interpretive analysis of the management processes in six interorganisational relationships illuminates the complex sense-making involved in transforming traditional management processes and creating interorganisational relationships at the Hospital. The use of the reflexive interpretive methodology is justified in Chapter 3 of the dissertation. Six narratives, or accounts, have been constructed to present the Manager’s reflective interpretations in the auto-ethnographic style. These ‘empirical materials’ also include the views of ‘significant others’ to add depth and enrich the researcher’s reflections. These views were gathered using semi-formal interviews. The researcher also had access to personal diary notes, Hospital documentation, such as memos, minutes of meetings. These were used to support the Manager/researcher’s reflective process.

The research setting was neither manipulated nor contrived but rather, it involved a naturally occurring sequence of activities, people and events that transpired in the course of the Hospital’s business operations. The context and the reflective/reflexive interpretation interact on multiple levels to enable new knowledge and understanding to emerge (Chikudate 1999a, 1999b; Klein & Myers 1999; Alvesson & Skolberg 2000; Cunliffe 2002). The following section considers the context more fully.

1.6.3 The Hospital Context

The hospital sector is comprised of both public and private hospitals. In this research the setting is that of a large private hospital. Private hospitals are of two
broad types: for-profit and not-for-profit (including publicly owned hospitals). The research was conducted in a large private not-for-profit hospital (the Hospital). The Hospital was primarily an acute care (tertiary) hospital, rather than a hospital for longer stay medical patients. This context was well suited to an exploration of managers’ organisational sense-making activities for several reasons. First, acute care hospitals are service industries. They provide a setting in which the personalised needs of patients create an environment in which observation, interpretation and action must be constructed and delivered effectively. While standards, guidelines and benchmarks are established in the acute health sector, there is also uncertainty, subjectivity and individualism which managers, and those who work in hospitals, must take into account when making decisions. The management of knowledge and the construction of meaning is central in delivering acute care services.

Secondly, private hospitals exist to provide the technology and nursing to enable others, such as clinical consultants to undertake specialist care of their patients. Numerous business relationships emerge from the many hundreds of clinical consultants who are accredited to admit patients and to work in the Hospital. In addition there are numerous other relationships formed with associated clinical support services, (such as blood suppliers, pathology and pharmacy services, diagnostic imaging services, anaesthetists, prosthetics suppliers, allied health workers), and non-clinical specialist services, (such as health funding organisations, food and cleaning service providers, consumable suppliers, biomedical engineers and maintenance services providers and technologists). While hospitals may symbolise quite traditional organisations, this network of relationships creates a complex backdrop. This must be co-ordinated to provide a level of ‘certainty’ so that clinicians, and other managers, are enabled to provide, with confidence, for the safety of vulnerable, acutely unwell patients. Such a context highlights the opportunities in a study of sense-making about managing interorganisational relationships for effective functioning.

Thirdly, the diversity of interorganisational relationships that characterise private hospitals means that there are numerous stakeholders with sometimes diverging interests. This adds complexity to the context because it virtually assures that
there will be occasions of diverse opinion, conflicting interpretation and power struggles during which the social processes of sense-making by stakeholders will construct, and reconstruct, workplace ‘realities’ around immediate patient needs.

This research explored the management of multiple interorganisational relationships in the period between 1998 and 2002. The specific interorganisational relationships were for the provision of diagnostic imaging services, pathology services, pharmacy services, patient and staff food services, environmental services (cleaning, patient ward support, waste management and patient transport) and human resources advisory services. The following section outlines the Australian private health care sector and the adoption of interorganisational relationship as business strategy.

1.6.4 Private Health in Australia

A significant shakeout and reshaping of the private hospital scene in Australia continues. Mayne Nickless’ aggressive entry into the health sector in the late 1990s, with its vertically integrated health services model, foreshadowed significant structural change within the private health sector. This change continues today and has seen the emergence of networks of private, for-profit hospitals. Even public hospitals are forming into networks of hospitals to cover large regions and service communities. There is evidence that the small stand-alone hospitals, whether of religious base or otherwise, have made poor returns and many of these businesses have disappeared in the absence of interested buyers, or new owners.

Private hospitals have adopted entrepreneurial growth strategies to gain market access, achieve operating efficiencies, and strengthen negotiating positions with funding health insurers. This has seen the emergence of hospital chains and some vertically integrated health care systems. Within this Australian scene players in the healthcare sector have also been active. It is beyond the scope of this literature review to go into depth about the private health sector. However, Table 1-1 summarises some of this activity and is derived from a review of selected articles
in daily newspapers, such as the Australian Financial Review, Asia Pulse, and the Wall Street Journal.

These headlines describe the significant structural change within the private health sector. They also show the emergence of the networked business model for hospitals. Key players in this hospital and health care restructure have been Mayne Health, Health Care of Australia, Sonic Healthcare (Australia), Ramsay Health Care, Benchmark Healthcare Group, Alpha Healthcare (Australia), and Healthscope (Australia).

### Table 1-1  Change within the Australian Healthcare Sector: 1995-2002

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 29,1995</td>
<td>Tenet Healthcare Corp will sell nearly all its foreign hospitals for US$337 million, with funds used to expand in the US.</td>
<td>Modern Healthcare</td>
</tr>
<tr>
<td>October 17, 1995</td>
<td>Mayne Nickless seeks to control Australian Medical Enterprises.</td>
<td>Financial Times London Edition</td>
</tr>
<tr>
<td>November 13, 1995</td>
<td>Tenet Healthcare sells almost 53% of Australian Medical Enterprises to Mayne Nickless.</td>
<td>Modern Healthcare</td>
</tr>
<tr>
<td>August 10, 1996</td>
<td>Health Care of Australia (HCoA) has purchased Dorevitch Pathology for a price rumoured to be around A$40 million (US$30.9 million).</td>
<td>International Healthcare News</td>
</tr>
<tr>
<td>October 23, 1996</td>
<td>Australian Hospital Care to acquire Allamanda private hospital in Southport for A$5 million in cash &amp; 4 million AHC shares at A$1.80 each lion.</td>
<td>Australian Financial Review</td>
</tr>
<tr>
<td>December 10, 1996</td>
<td>Health Care of Australia has secured more than 15 per cent of the Australian private pathology market following acquisition of Hampson Pathology of New South Wales.</td>
<td>International Healthcare News</td>
</tr>
<tr>
<td>August 19, 1997</td>
<td>Alpha Healthcare (Australia) has seen the Foreign Investment Review Board approve the acquisition of a 38% stake in the company by Sun Healthcare (US).</td>
<td>Australian Financial Review</td>
</tr>
<tr>
<td>October 28, 1997</td>
<td>Nursing Home Properties to spend up to (GBP) 60m buying new care homes after forming a joint venture with Lend Lease.</td>
<td>Financial Times London Edition</td>
</tr>
<tr>
<td>November 24, 1997</td>
<td>Sun Healthcare Group (Albuquerque, NM) acquired majority stake in 6 hospitals in Australia from Moran Health Care Group (Sydney, Australia) for US$16 million.</td>
<td>Modern Healthcare</td>
</tr>
<tr>
<td>October 5</td>
<td>Sonic Healthcare (Australia) to acquire Australian and Asia Pulse</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Source</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>1999</td>
<td>New Zealand operations of SGS Medical Group (Geneva, Switzerland) for A$502.68 million.</td>
<td></td>
</tr>
<tr>
<td>April 10, 2000</td>
<td>Mediboss, clinical software firm, is being acquired by Health Communication Network (Australia), Internet healthcare firm.</td>
<td>Asia Pulse</td>
</tr>
<tr>
<td>July 4, 2000</td>
<td>Mayne Nickless Diagnostic Services acquires Corporate Wellness Solutions, a corporate health services group, for an undisclosed sum.</td>
<td>Asia Pulse 202 32.</td>
</tr>
<tr>
<td>July 11, 2000</td>
<td>Sonic Healthcare is acquiring 12.3 million shares in Foundation Healthcare (both Australia) for A$21.89 million, enabling Sonic to grow its diagnostics businesses; Sonic also plans to foray into radiology in Australia.</td>
<td>Asia Pulse</td>
</tr>
<tr>
<td>November 1, 2000</td>
<td>Mayne Nickless (Australia), healthcare and logistics firm, to complete sale of parcel delivery businesses in UK and Ireland for A$535 million to GeoPost Intermediate Holdings, in December 2000.</td>
<td>Asia Pulse</td>
</tr>
<tr>
<td>November 22, 2000</td>
<td>Mayne Nickless (Australia), healthcare and transport group, to launch takeover bid for Australian Hospital Care; firm would gain extra 1,616 private beds from takeover, vs. current capacity of 4,518 private beds.</td>
<td>Asia Pulse</td>
</tr>
<tr>
<td>November 22, 2000</td>
<td>Sonic Healthcare (Australia), pathology and medical diagnostic group, to merge with Radclin Medical Imaging (Australia), radiology practice, which will raise revenue to A$87.46 million/year.</td>
<td>Asia Pulse</td>
</tr>
<tr>
<td>November 24, 2000</td>
<td>Mayne Nickless sells Aus$100 million in shares through Morgan Stanley Dean Witter; Mayne Nickless is acquiring Australian Hospital Care in a deal worth approximately A$200 million.</td>
<td>Euroweek</td>
</tr>
<tr>
<td>November 29, 2000</td>
<td>eHealthcareasia (Hong Kong) completes its acquisition of MedWeb (Australia), an healthcare industry connectivity firm; following the deal, eHealthcareasia accounts for 25% of the market for clinic management systems in Australia.</td>
<td>Asia Pulse</td>
</tr>
<tr>
<td>March 6, 2001</td>
<td>I-Med (Australia), a medical imaging firm, plans to form new joint venture company Regional Imaging with Riverina Medical Imaging and Border Medical Imaging.</td>
<td>Asia Pulse</td>
</tr>
<tr>
<td>April 9, 2001</td>
<td>Ramsay Health Care, through subsidiary Ramsay Centauri, launches an A$17.44 million cash takeover offer for rival Alpha Healthcare (Australia), a hospital management group.</td>
<td>Asia Pulse 448 15.</td>
</tr>
<tr>
<td>April 26, 2001</td>
<td>Healthscope (Australia), a private hospital owner, acquires the Dubbo Private Hospital and the Palm Beach Currumbin Private Hospital, both in Australia, for an undisclosed sum from Sun Healthcare.</td>
<td>Asia Pulse 143 14.</td>
</tr>
<tr>
<td>May 18, 2001</td>
<td>Healthscope (Australia) acquires The Sydney Clinic, a private psychiatric hospital.</td>
<td>Asia Pulse 117 13.</td>
</tr>
<tr>
<td>May 25, 2001</td>
<td>Sonic Healthcare (Australia), radiology and diagnostic group, withdraws bid to acquire Radclin Medical Imaging, on grounds of adverse issues uncovered via due diligence process.</td>
<td>Electrical &amp; Radio Trading</td>
</tr>
<tr>
<td>September 5, 2001</td>
<td>Ramsey Health Care of Australia reports net profit for the year to 30 June 2001 up by 140% to A$16 million.</td>
<td>Asia Pulse</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Source</td>
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</tr>
<tr>
<td>October 3, 2001</td>
<td>Mayne Nickless, healthcare and logistics group, completes 97.43% acquisition of FH Faulding (both Australia), pharmaceutical firm; will proceed with divesting the latter's international operations.</td>
<td>Asia Pulse</td>
</tr>
</tbody>
</table>

The next section introduces the management of interorganisational relationships in the Australian private health sector. The private health sector has, by nature, evolved on the basis of business relationships between clinicians and hospital’s providing nursing and other support services. These ‘relational structures’ have developed in contrast to public health services wherein governments fund and employ most clinicians to deliver health care. Over time these business partnerships and outsourcing initiatives have also begun to emerge in public health care service.

1.7 **Interorganisational Relationships in the Australian Private Health Sector**

The Hospital in this research is not alone in forming relationships with external organisations to enhance its business. The very nature of private hospitals ensures that the management of hospital-clinician relationships is essential to the admission of patients. Clinician relationship management is a designated function within the private hospital strategic and operation levels.

The acquisition of other clinical and non-clinical services is also increasingly more common. There is an emerging body of literature about public sector (Hodge 2000; Department of Treasury & Finance 2000) and the not-for-profit community health networks but less about individual private hospital partnering. This may be in part due to the competitive nature of the private health sector wherein management strategies and performance are protected except for public information about share values and market movements.

Evidence that service partnerships in hospitals are growing can be seen by examining the promotional materials of some of the larger private sector
outsourcing firms (Tempo Health Support Services 2002). Such materials show widespread adoption of the relationship strategy across Australian hospitals for a range of services that include catering, cleaning facilities management. As a not-for-profit hospital the Hospital that is central to this research has few comparable competitors. Movements of employees between the private hospitals within the sector contribute to knowledge about management activity. This research makes a contribution to research and professional practice by examining interorganisational relationship management in the Australian private health sector.

1.8 Contributions of the Research

This research is based on one organisation in one industry sector during the period 1998-2002. Few researchers in the organisation field have had similar access, over such a long period of time, to explore the daily social interactions of managers, and others, in their sense-making activities as they influence how interorganisational relationships function.

Various research lenses have been adopted elsewhere to examine the performance of interorganisational relationships. This research used the analytic lens of a client manager’s activities enacted within the interorganisational relationships context. These activities are socially recognised routines such as meetings, induction seminars, negotiations and memos.

An interpretive perspective using qualitative methods has enabled rich understandings to be developed about managers’ sense-making in constructing interorganisational relationships. In time, similar investigation, in different sectors, will examine diverse services relationships over time and add further to this body of knowledge. Such further research will enable comparisons to be made that can assist the professional practice of interorganisational relationship management.

The research is focussed on the management process during the phase of interorganisational relationship maintenance or construction. This phase of implementation excludes the service provider selection and dissolution phases when the commitments to commence and dissolve the interorganisational
relationships are taken. All but one of the service providers in this research was ‘in place’ prior to the commencement of the research. None of them was subject to a competitive selection process. This history may have contributed to nuances in the Manager’s sense-making as she managed the construction of the interorganisational relationships.

The research is conducted in a not-for-profit private sector organisation where-in traditional interpretations tend to suggest that managers in these settings develop unique approaches to their accountabilities. In so doing the client managers in this research may respond differently to those in other organisations. The perspectives presented are also those of a client manager and, therefore, do not examine those of the service provider in the interorganisational relationship.

As noted earlier, the researcher was an active participant in management of the relationships over the period 1998 to 2002. The research, thus, uses information that is based upon the researcher’s direct experience and memory of events. It, therefore, constitutes a personal reflection and interpretation. Other observers may make different interpretations based on their own set of experiences, structures, and environmental and social influences. This research contributes to the ongoing reflection by those other observers. It also brings reflexive interpretive practice into ongoing management education.

1.9 Structure of the Dissertation

The thesis is presented in five chapters. This chapter provides a background to the research. Chapter 2 presents a review of the relevant literature and covers various theoretical perspectives relating to the subject of the study. In Chapter 3 the research methodology is described, detailing the research design, data collection and data analysis. Chapter 4 presents the findings in the form of six constructed narratives about the Manager’s interorganisational relationship management process. These narratives present the empirical ‘data’ and they are the basis for further reflective discussion in Chapter 5. The conclusions and the contribution of the research are presented in Chapter 6. Appendices and references are provided at the end of the dissertation.
1.10 Chapter Summary

This chapter has identified the research problem that emerged from the researcher’s experience of managing interorganisational relationships and briefly described the Hospital setting of the interorganisational relationship forming process. The research questions have been defined around the theme of interorganisational relationship management. Key terms have been defined and the purpose of the research and its contribution has been identified. The research strategy has been introduced briefly. Chapter 2 follows and presents a review of some of the relevant literature on interorganisational relationships, organisation, sense-making and organisational schema. Contributing research streams are identified along with some of their emerging themes that contribute to the reflective interpretation in this research about management activity associated with interorganisational relationships.
2 REVIEW OF RELATED LITERATURE

2.1 Introduction

‘Organisation’ is a social process through which people accomplish activity (Westley 1990). Business relationships between organisations create new contexts that challenge people’s understandings about how they should work. Thus, decisions to form interorganisational relationships may be associated with energetic, adaptive behaviours by multiple stakeholders. Managers in interorganisational relationships have particular responsibilities to make these arrangements work. Sense-making is critical to all organisational activity (Weick 1995) and managers’ sense-making activities contribute to the forming, or the construction, of interorganisational relationships. They are responsible to co-ordinate and lead others in this construction of new workplace ‘realities’ and to achieve their organisation’s objectives.

Interorganisational relationships give rise to boundary spanning contexts. Such settings may confront people's sense of their traditional work practices. This change acts like a cue to managers, and others, to stimulate their sense-making. In a process of interaction participants begin to reinterpret the routine ways that responsibilities have been exercised. Through social interaction people ask questions, seek clarifications, test understandings, devise new ways of relating, relinquish practices, innovate and explore shared behaviours. They construct interpretive accounts and share them with others. Sense-making and sense-giving activities both precede decision making and follow it (Weick 1993; Maitlis 2005). In this recursive process people begin to reconstruct existing knowledge and construct new understanding. Sense-making is, thus, a socially interactive and contextual process in organisational activity. Over time, social activities by managers and others, affect the formation of interorganisational relationships.

Extant research on interorganisational relationships comes from a range of disciplines and includes contributions from economics and marketing, sociology, psychology and organisation. These disciplines contribute different perspectives and highlight the extensive and complex nature of relationships that form between
organisations. Much of this research is, however, concerned with understanding why the interorganisational strategy has been adopted and how well it performs against strategic objectives. Less attention has been paid to the contributions of managers and the social processes in interorganisational relationship construction.

This research makes a contribution to address this gap. It builds on the work of others in the organisation field (Weick 1979, 1993; Chikudate 1999a, 1999b; Brown & Humphreys 2003; Maitlis 2005), and those who have begun to explore sense-giving and the contribution of emotion in decision-making (Westley 1990; Goleman 1995, 1998; Mayer & Salovey 1997; Dutton, Ashford, O’Neill & Lawrence 2001; Diefendorff & Gosserand 2003). Further, it takes findings from those who have explored the cognitive building blocks of social systems (Goffman 1974; Ruef & Scott 1998; Feldman 2000; Feldman & Pentland 2003). These contributions have been incorporated into a reflexive interpretation about interorganisational relationship management in a large not-for-profit hospital. In this way the research also highlights the contribution of an interpretive auto-ethnographic approach in the construction of new knowledge about interorganisational relationship management.

This chapter proceeds as follows. Section 2.2 defines some of the more frequently referenced types of interorganisational relationships. In Sections 2.3 and 2.4 this research is positioned to conceptualise interorganisational relationships as emergent social systems in boundary spanning ‘spaces’ between co-operating organisations. They, therefore, create unique sub-contexts, often within the context of a wider organisational form. Sense-making is introduced in Section 2.5. Managers make sense of collaborative contexts of interorganisational relationships and reconstruct ‘traditional’ management processes to enable the new organisational form to emerge. This creation process may be fraught with danger and the social interactions between participant actors, managers and leaders can have both positive and negative consequences on the emergent organisation. This also includes discussion on the importance of structure and its embeddedness within sense-making processes. This is followed in Section 2.6 by discussion of other organisational attributes and influences that contribute to the functioning and dynamic nature of interorganisational relationship construction. Section 2.7
identifies a model for the temporal dimension of this research. It prepares to narrow the focus to a phase after the interorganisational relationships have been initiated and places it in the continuing implementation process of interorganisational relationship forming and functioning. The chapter concludes with a summary in Section 2.8.

2.2 Types of Interorganisational Relationships

Pearce (2001) defined interorganisational relationship as the purposeful, collaborative and ongoing connection between two or more organisations for the pursuit of shared or complementary goals. There are many types of interorganisational relationships. This variation is sometimes described by different levels of control, or governance, and legal structure.

At the one end there are equity arrangements, such as joint ventures (Beamish & Banks 1987; Inkpen & Beamish 1997; Mockler 1997; Hennart, Roethl & Zietttlow 1999; Barringer & Harrison 2000; Johnson, Korsgaard & Sapienza 2002) which involve partners investing shared equity in a new entity. At the other end of this continuum are various non-equity interorganisational relationships, described by contracts and agreements and including franchises. These arrangements are most often for the purposes of procurement and supply chain, as well as delivery of services (Loh & Venkatraman 1992; Lei & Hitt 1995; Gilley & Rasheed 2000).

The research literature in the organisation field also refers to ‘strategic alliances’ (Lei & Slocum 1991; Das & Teng 1998) and ‘networked’ (Cheadle, Berry & Wagner 1997; Fulop 2004) forms of organisation. These concepts of interorganisational relationship extend the various supply chain functions, at the macro or system level and may include those referred to in the Mockler (1997) schema as contracting relationships. Figure 2-1 shows a categorisation of interorganisational relationships based on one presented by Mockler (1997).
Figure 2-1   Types of Interorganisational Relationships

Source: Adapted from Mockler (1997, p. 393)
There are other researchers, such as those in the field of knowledge management, who have discussed and analysed organisational forms using the concepts of communities of practice (Pascarella 1997; Snyder 1999; Wenger & Snyder 2000; Lasker et al. 2001), communities of purpose (Braganza 2005) and competence (Dotan 2002; Smith 2005). These organisational forms may emerge within existing larger organisations as forms of functional relationship and between distributed participants in different organisations as cross-functional organisation constructions.

Sections 2.2.1 to 2.2.5 describe five interorganisational relationship arrangements most often referred to in the research literature: namely joint ventures, consortia, outsourcing, networks and strategic alliances. Each is discussed in turn.

2.2.1 Joint Ventures

A joint venture is a legal and economically separate entity created when two or more parent organisations pool a portion of their resources to create a separate, jointly owned organisation to pursue certain strategic objectives (Inkpen & Beamish 1997; Hennart et al. 1999; Johnson et al. 2002; Li, Karakowsky & Lam 2002; Child & Yan 2003). Joint ownership creates some security and commitment to the mutual benefits of collaboration (Kogut 1988).

Joint ventures enable a range of objectives. Organisations form international joint ventures to facilitate access into new markets, particularly foreign markets (Beamish & Banks 1987; Lei & Slocum 1991; Li et al. 2002; Child & Yan 2003). Nooteboom, Hans & Niels (1997) identified a number of reasons for international joint ventures, including sharing of fixed costs and risks involved in innovation and production, access to new competencies access to new markets, socio-political legitimacy and local resources.

2.2.2 Consortia

Consortia are specialised co-operative arrangements, typically consisting of a group of organisations for whom joining forces satisfies the need of all parties (Barringer & Harrison 2000). Research consortia enable knowledge development and transfer
between members at the pre-competitive stage. Co-operation in this way provides benefits beyond that which the individual firms could achieve alone. Consortia may have a central administrative authority and a governing board composed of representatives of the members.

Intercollegiate associations of liberal arts colleges comprise examples of consortia formed in the early 1960s in America to promote co-operation (Fuller 1988; Neal 1988). Through these associations, colleges engaged in a variety of co-operative endeavours, including government lobbying, joint marketing and fundraising, joint purchasing and the sharing of physical, technological and human resources. Kraatz (1998) found that liberal arts consortia facilitated communications by enabling personnel relationships between organisations and through offering opportunities for regular, informal interaction. Kraatz’s study identified that interdependence between partners in the consortiums was low with little, if any, formal governance between the parties making it relatively easy for partners to leave the consortium.

Consortia have also formed in the technology and manufacturing industries between research and development organisations, (Aldrich & Saksi 1995; Gibson & Rogers 1994; Browning, Beyer & Shetler 1995). Consortia have been found to be affected by management difficulties and disagreements between members over matters such as the types of services to be provided by the consortium (Evan & Olk 1990), by visionary leadership and adaptive behaviours (Browning et al. 1995; Ring & Van de Ven 1994).

### 2.2.3 Outsourcing

The term ‘outsourcing’ is most commonly used to refer to the divestiture and buyback of the more routine operational services of a business (Lei & Hitt 1995; Unenberger & Sweet 2003). In one study of information technology, outsourcing was defined as ‘the significant contribution by external vendors in the physical and/or human resources associated with the entire or specific components of the information technology infrastructure in the user organisation’ (Loh & Venkatraman 1992, p. 9).
Outsourcing as divestiture and buyback also occurs in the public sector and is often associated with privatisation of publicly funded services (Hodge 2000; Johnson 2000). Outsourcing in government refers to ‘contracting with a private sector firm to take responsibility for a function or process for which the government remains accountable’ (Hunter & Healy 2002, p. 4). Figure 2-2 summarises this interpretation of outsourcing. Hunter & Healy (2002) stop short of equating government outsourcing with ‘privatisation’, wherein the government transfers accountability for the service.

**Figure 2-2  The Meaning of Outsourcing**

<table>
<thead>
<tr>
<th></th>
<th>Privatisation</th>
<th>Government organisation moves to the private sector. Government is no longer accountable for the activity.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Private finance initiative</td>
<td>Public and private resources pooled to develop, operate, and own public facility and service. Employees may or may not be affected.</td>
</tr>
<tr>
<td></td>
<td>Transfer services to a new firm</td>
<td>Private sector contracts to provide services previously undertaken by government. Employees may or may not be re-deployed.</td>
</tr>
<tr>
<td></td>
<td>Sourcing new services</td>
<td>Government contracts for services not previously done by government. Current positions not affected.</td>
</tr>
<tr>
<td></td>
<td>Self augmentation</td>
<td>Government buys services that don’t compromise entire function or process. Employees not affected.</td>
</tr>
</tbody>
</table>

*Source: Adapted from Hunter & Healy 2002*

The tradition has been to outsource ‘non-core’, or peripheral, activities (Gilley & Rasheed 2000). Core competencies have been identified as ‘those where an organisation can achieve definable pre-eminence and unique value for customers’ (Quinn & Hilmer 1995, p. 49). Non-core activities are most often those considered integral to the functioning of an organisation but not critical, strategically, nor characterised by scarce or special competencies (Gilley & Rasheed 2000).

There is debate about whether or not outsourcing is a strategic relationship decision. In an article about information technology outsourcing, Lacity & Hirschheim (1993) questioned the widespread endorsement of outsourcing as strategic relationship. They claim that the term ‘strategic partner’ is unsuitable because the profit incentive is not
shared. Service providers’ managers are rewarded for additional client billings that are at the ‘expense’ of the ‘partner’.

In contrast, Gilley & Rasheed (2000) observed that outsourcing is more than the simple procurement of a product or service. They suggest that understandings need to capture the underlying strategy about choice in the decision to outsource. An understanding about outsourcing that fails to capture the sense of continuity and business integration in the decision to outsource, fails to define a decision which is more than the simplest form of procurement. Outsourcing represents the fundamental decision to reject the internalisation of an activity. In this way, outsourcing is a highly strategic decision that has the potential to cause ripple effects throughout the entire organisation (Gilley & Rasheed 2000).

Gilley & Rasheed (2000) propose that outsourcing arises in two ways. First, through the “substitution” of external purchases for internal activities (substitution of internal activities by external purchases), such as shifting production or services to an external source. In this way outsourcing can be viewed as reducing or discontinuing a firm’s involvement in successive stages of production. This constitutes vertical dis-integration or “unbundling” of an organisation’s business activities.

The second definition of outsourcing is reserved for those situations in which firms purchase goods or services from outside organisations even when those goods or services have not been completed in-house in the past. This is abstention-based outsourcing and is unique form of basic procurement because the former only occurs when the internalisation of the good or service outsourced was within the acquiring firm’s capabilities. This form of outsourcing also reflects a decision to reject internalisation (Gilley & Rasheed 2000).

2.2.4 Networks

Recently researchers have begun to describe networked organisations (Metropolitan Hospitals Planning Board, 1995a, 1995b; Cheadle et al. 1997; Lasker et al. 2001; Fulop 2004) that are characterised by business to business interdependencies.
Networked, or ‘virtual’ organisations, have been facilitated by internet and ‘on-line’ business processes (Quinn 1992; Orlikowski & Yates 1994; Hedberg 1997).

Networked organisations comprise groups of ‘unbundled’ organisations (Hagel & Singer 2000), or distributed, temporary, information-intensive communities (Orlikowski & Yates 1994) collaborating across the value chain to deliver and develop products or services to others. Nike and Cisco Systems are primary examples of networked organisations. Brown, Durchslag & Hagel (2002) refer to these companies as ‘orchestrators’. Each has an extensive network of loosely coupled suppliers representing all stages in the production (Nike) and service (Cisco) processes. Nike broadly specifies required outcomes for each stage of the process. The multiplicity of players in the networks promotes innovation and customer loyalty.

In contrast to these commercial networks has been the emergence of more loosely coupled community-based health networks (Metropolitan Hospitals Planning Board 1995a, 1995b; Cheadle et al. 1997; Lasker et al. 2001). Governments in the USA and Australia, for example, have invested heavily in these community based collaborations to bring health consumers and primary health services together to improve community health, health care delivery and overall functioning of the health system (Butterfoss, Goodman & Wandersman 1996). These networks, or communities of practice and interest, attempt to ‘enable people and organisations to support each another by leveraging, combining, and capitalising on their complementary strengths and capabilities’ (Lasker et al. 2001, p. 180). In Australia, the Victorian state government has recently implemented a ‘primary care partnerships strategy’ in its attempt to broaden a collaborative approach to better facilitate referral pathways between health services and deliver integrated health practice (Victorian Government Department of Human Services 2004). Further, Australian state governments (Nisbet & O’Donnell 1992; Metropolitan Hospitals Planning Board 1995a, 1995b; Liaw, Karabatsos, Scarfo & Pirotta 1997; Muetzelfeldt 1999) have formalised acute hospital networks as integrated service systems. These are also linked to the community health sector to enable continuity in the provision of integrated community health solutions and patient safety (Dotan 2002).
Snyder (1999) and others (Armstrong & Hagel 1997; Hargadon & Sutton 1997; Krackhardt & Hanson 1993) have given attention to networks of individuals that form within, and across, organisations, and which serve as channels for information flow, innovation and knowledge construction. In an interesting analysis Synder (1999) developed the example of a start up fast-food business, Gaia’s Place, using the concept of communities of practice and interest, and from which was developed a set of competencies for organising communities and knowledge networks to build customer loyalty (sustainable market) and service delivery systems. The contribution of this analysis was in its use of the communities of interest concept as a model for business planning a new commercial activity. This approach is similar, albeit on a much smaller scale, to that of large organisations that form strategic alliances with other organisations when they desire new offshore market penetration.

2.2.5 Strategic Alliances

Gulati and Singh (1998, p. 293) defined strategic alliances as the ‘voluntary arrangements between firms involving exchange, sharing, or co-development of products, technologies, or services’. United Technologies, for example, is engaged in more than one hundred worldwide collaborations. Others include the 1996 alliance between traditional competitors: General Electric (US) and Rolls-Royce (British) to create an engine for new military strike aircraft. Mitsubishi Motors and National Australia Bank have used strategic alliances to enter new markets overseas. Keridge, Newby, McNeill, Henry, Hill, Day, MacDonald, Stokes, & Henderson (2005) undertook an initial exploration of co-operative partnerships between the pharmaceutical industry and medical organisations in Australia and identified close relationships based in research and development, supply and patient care.

There is some ambivalence when it comes to precisely classifying what types of co-operative arrangements can be termed ‘strategic alliances’ (Das & Teng 1998a; Zollo, Reuer & Singh 2002). In the Mockler (1997) schema, those interorganisational arrangements wherein organisations share control over the performance of assigned tasks are called strategic alliances. This distinction is consistent with other researchers (Yoshino & Rangan 1995) who restrict use of the term to those arrangements where firms are tied substantively to each other due to long term
interdependence, shared control, and joint equity contributions. Conversely, there are others who prefer a more inclusive approach and maintain that virtually all forms of interorganisational relationship constitute strategic alliances (Das & Teng 1998a; Sarker, Echambadi & Harrison 2001).

While researchers might debate categorisation issues, the emergence of these organisational arrangements from interactive, communicative behaviours, between decision makers and managers, is less well researched. This is a gap that this research seeks to address. The following section considers interorganisational relationships as forms of organisation that emerge from dynamic, social interactive processes between people. The notion of ‘organisation’ as a process has been championed by various researchers (Weick, 1979, 1987, 1993; Wiley 1988; Westley 1990; Brunsson & Sahlin-Andersson 2000; Kramer 2002). Weick (1987, pp. 97-98) observed that ‘interpersonal communication is the essence of organising because it creates structures that then affect what else gets said and done and by whom …’ The structures themselves create additional resources for communication such as hierarchical levels, common tasks, exchangeable commodities, and negotiable dependencies.’ This view is adopted in this research to enable the researcher to explore the dynamics involved as participants (social actors) make sense of, and construct, the contemporary organisational phenomenon that is the interorganisational relationship.

2.3 Interorganisational Relationships as ‘Organisation’

Mintzberg (1983) identified five criteria for a simple organisational structure. These include co-operation by direct supervision, strategy planned at the top, little formalised behaviour, organic structure, and the person in charge tending to formulate plans intuitively, meaning that the plans were generally a direct extension of his own personality. These criteria underplay a duality that makes the interorganisational relationship operationally challenging. This duality captures the contribution of the individual, and structure, in organisation construction.

As part of this shift in focus to the level of social interaction it is proposed to conceptualise the interorganisational relationship as a process of organisation (Weick,
1979, 1993; Wiley 1988; Westley 1990; Brunsson & Sahlin-Andersson 2000; Kramer 2002). Organisation has been defined as ‘a series of interlocking routines, habituated action patterns that bring the same people together around the same activities in the same time and places’ (Westley 1990, p. 339). Social actors in an interorganisational relationship create routines, or habituated action patterns, through their interactions. These actors come together from the pools of people identified by their respective organisations for the common purpose of delivering services at the same place or time (Weick 1993; Kramer 2002). Westley’s (1990) definition simultaneously embodies dynamism and an inherent fragility that stems from the notion that an actor’s structuring of routines can influence the quality, or effectiveness, of an interorganisational relationship. Over twenty years ago Weick (1979) described organisations as dynamic processes, not merely complex systems. Weick (1993) also identified that organisations are characterised by generic subjectivity, or in other words, that roles and rules exist that enable individuals to be interchanged without detriment to the ongoing pattern of activity. This view has been further developed following more detailed analyses of organisational disasters where it has been shown that breakdowns in leaders’ sense-making highlights an inherent fragility in institutionalised routines, particularly when actors face new and challenging situations that may have significant, or disastrous outcomes.

Organisations have been viewed as instruments for other actors, such as parent companies, departments have been viewed as instruments of head office, or public services as instruments for politicians (Brunsson & Sahlin-Andersson 2000). This conceptualisation enables us to also view interorganisational relationships on two levels. On one hand, the agent is the relationship itself and has given accountabilities to its actors – the principals. In the situation of co-operating organisations there is, therefore, a duality in the agent/principal connection. On the other hand, the client members of the interorganisational relationship and the provider members of the interorganisational relationship are each in a form of agency relationship to their own principal organisations.

The ‘agent organisation’ possesses organisation-like features, such as systems for monitoring and recording performance, operating rules and practices, managers and leaders, boundaries, objectives and goals, suppliers and customers. One of the
inherent problems in this view of interorganisational relationships as organisations is
the ‘incompleteness’ that results from the need to consider latent, institutionalised
influences, norms and standards, and external values, that characterise the principals
who have control over the organisation’s activities. This is why interorganisational
relationships may be challenging to implement.

One consequence of this diversity may be an inherent tension between the roles
associated with client agents and provider agents, even though the interactions
between these participants are orientated to creating co-operative and collaborative
meanings for shared outcomes. The tension between competition and co-operation
may interrupt the agents and the actors’ abilities to make sense of what is happening
(Chikudate 1999a, 1999b). This conceptualisation, therefore, has some fragility, and
complexity, not the least for the agents or participant members.

Proponents of interorganisational relationships envisage the opportunities that come
with the content differences in the cognitive structures of the co-operating
organisations (Lowstedt 1993; Walsh 1995). This top-down view belies the
implementation difficulties in such co-operative organisation structures. Empirical
material suggests that the failure rate for interorganisational relationships is high. The
role, and performance, of actors in the implementation of interorganisational
relationships may contribute to the extent to which the promise of the strategy is
fulfilled.

The juxtaposition of two distinct organisations to form a new interorganisational
relationship lays the foundation for new ‘reality’ construction. Existing
institutionalised structures and systems are tested and struggles take place between,
and within, individuals and organisations, as actors’ sense-making processes affect
construction of the interorganisational relationship, and new relations within the
partnering organisations.

Some of the research on power and legitimation (Voyer 1994) in organisations has
relevance for interorganisational relationships. Sociologists such as Weber (1968)
view ‘legitimation’ as a belief system that guides actors toward some sense of
obligatory order, or exemplary form, in relationships with others, or what they do
This concept can be applied to power structures within organisations, where employees assume roles, and develop perspectives, that reflect subordination to order (socially constructed systems of norms, values and beliefs) because of its traditional nature, or because it has been legally constituted (Suchman 1995; Ruef & Scott 1998). Variations in the strength of such beliefs may be reflected in different structures, stability and operations (Meyer & Rowen 1977; Suchman 1995). Ruef & Scott (1998) and DiMaggio & Powell (1983, 1991) and others have attempted to operationalise the concept of legitimacy using normative, regulative and cognitive components of organisations. Cognitive elements are the building blocks of social systems and encompass ‘the rules that specify what types of actors are allowed to exist, what structural features they exhibit, what procedures they can follow and what meanings are associated with these actions’ (Ruef & Scott 1998, p. 879).

An organisation’s institutionalised routines provide the backdrop for inertia, resistance and power struggles (Voyer 1994; Edmondson, Bohmer & Pisano 2001). These routines comprise part of an organisation’s store of tacit knowledge, and actors may unconsciously draw on these routines in ways that constrain the adaptive behaviours necessary for the formation of enduring collaborative routines (Ranson, Hirings & Greenwood 1980; Weick 1993; Chikudate 1999a, 1999b; Feldman 2000; Brown & Humphreys 2003; Hardy, Lawrence & Grant 2005). Managers of interorganisational relationships become the observers who, along with other stakeholders, monitor and participate in assessing conformity of the other party to their own specific standards or models of legitimacy. This difficulty points to the inherent fragility in interorganisational relationships. The failure of some interorganisational relationships may be understood in terms of changes in contextual influences, or contradictions, which result in a prolongation or a failure, of sense-making and structure reformation. The balance of power in relationships between constituencies in interorganisational relationships will reflect the outcome of cognitive processes used by the actors to legitimise the new ‘reality’.

Having established that interorganisational relationships have many of the attributes of ‘organisations’ the intention now is to consider their formation. This is commenced with a discussion about structure and socially constructed ‘reality’ in Section 2.4. This section draws on the theory of structuration, as well as the notion of
self-organisation, and establishes the inter-subjective process in organisation construction. Then, in Section 2.5 the notion of sense-making is introduced. This includes discussion of interpretive organisational schema such as frames and scripts in Section 2.5.1 and knowledge stores in organisational routines in Section 2.5.2.

2.4 Structure and Socially Constructed Reality

In the interpretivist perspective social context is important in meaning construction. ‘All human action is carried on by knowledgeable agents who both construct the social world through their action, but yet whose action is also conditioned by the very world of their creation’ (Giddens 1981, p. 54).

Structuration theory posits that the rules and resources drawn upon in the production, and reproduction, of social action are at the same time the means of system reproduction. In this respect, human social activities are recursive because they are continually recreated by the actors whereby the latter express themselves as actors. In and through their activities, agents reproduce the conditions that make these activities possible (Giddens 1984). There is, thus, a duality of structure as the structural properties of social systems ‘are both the medium and outcome of the practices they recursively organise’ (Giddens 1984, p. 25).

Giddens’ structuration theory holds that people are social constructs and that their institutions are constructs upheld by the actions of humans acting according to their images of what reality is. Structures only exist within and through human practices. Giddens (1984, p. 17) wrote:

Social systems, as reproduced social practices, do not have ‘structures’ but rather exhibit ‘structural properties’ and … structure exists, as time-space presence, only in its instantiations in such practices and as memory traces orienting the conduct of knowledgeable human beings … The most deeply embedded structural properties, implicated in the reproduction of social totalities, I call \textit{structural principles}. The practices which have the greatest time-space extension within such totalities can be referred to as institutions.

Structures give actors roles and norms, or definitions, of what ought to done, be, and felt. Actors reproduce structures, create them and recreate them, conceptualising and
conceiving them through interaction with others. This structuration process is the essence of ‘reality’ construction. The experience of actions enables actors to also draw from what they know (knowledge stores) in a process of reflection and through this process, social reconstruction occurs. Actors exist within certain social contexts and it follows that, in time and space, certain actions are routinised and organisation forms. Such routines have also been referred to as institutionalised activity – the ways things are ‘traditionally done’.

Routinised actions manifest as rules, codes, policies and practices, guides and standards that, in themselves, are constituted from other people’s actions so far. Reed (1991) described this as contextual reality and within which social action is motivated to create and maintain the institutions and traditions that express some conception of the ‘right’ behaviour. These repeated forms of interaction are constituting systems, or, ‘enduring cycles of reproduced relations’ (Giddens 1984, p. 131) and are compared to structures that are moments recursively involved in the (re)production of social systems.

Actions may have intended and unintended consequences. According to structuration theory, people do not always depend on, nor perfectly replicate, the past because the conditions under which subsequent action is taken may be different. Variations in perceptions and thinking (sense-making) create different realities. Weick (1979, 1993) referred to ‘stunted enactment’ and ‘interactive disintegration’, respectively, to describe situations when sense-making compromised successful outcomes due to a failure by vulnerable actors to engage in sufficiently rich modes of sense-making when dealing with complex organisational life. Similarly, research by Chikudate (1999a, 1999b) on Japanese industry suggested that institutionalised structures and systems explained a state of myopia that stultified organisational change. Collective myopia occurred when conformity to the ongoing institutions went unquestioned and occurred when the collective (inter-subjective) reality of the group was accepted as ‘objectivated facts’ (Chikudate 1999a). Brown & Humphreys (2003), in an interpretive study of change in United Kingdom colleges, identified the hegemonic and psychic prison effects of an inter-group struggle to make sense of organisational change.
Using structuration theory it is possible to view interorganisational relationships as social systems formed by the restructured practices of social actors. Such structures cannot exist in and of themselves. In the process of making sense of what may initially be contradictory meanings, people engage in processes of redefining, protecting, defending, expanding and altering their routines, their privileges and power, and their functions, so that the successive new ‘realities’ unfold.

Fuchs (2003, p. 144) argued for an integration of the theory of structuration into a theory of social self-organisation on the basis that they were conceptually close. He proposed that society could only be explained consistently as self-producing when it was accepted that man was a social being with central importance in the reproduction process:

Society produces man [sic] as a social being and man produces society by socially coordinating human actions. ‘Man’ [sic] is the creator and created result of society; society and humans produce each other mutually. Such a conception of self-organisation acknowledges the importance of human actors in social systems and closely related to Giddens’ duality of structure. Saying that man [sic] is the creator and created result of society corresponds to Giddens’ formulation that, in and through their activities, agents reproduce the conditions that make these activities possible.

This conception of structuration and self-organisation is illustrated in Figure 2-3.

**Figure 2-3   Self Organisation of Social Systems**

Source: Fuchs 2003, p. 145
Through social interaction, new qualities and structures emerge. ‘Bottom-up’ emergence is called agency. New systemic qualities and structures are not predictable nor are they reducible. Social structures, in turn, influence individual actions and thinking, therefore, they constrain and enable actions. This is top-down emergence where new individual and group properties emerge. Knowledgeable actors, thus, face structures that are enabling and constraining (Wright, Manning, Farmer & Gilbreath 2000; Fuchs 2003).

This conception of organisation provides a useful framework for the consideration of the actions of actors in making sense of, and structuring the emergence of an interorganisational relationship. The actors reconstruct their existing social system and create a new interorganisational ‘reality’ and become a part of it. This new reality enhances the opportunities inherent in the strategic decision by organisations to adopt the relational strategy.

Against this theoretical background researchers have explored the individual (subjective) structuring process as sense-making (Read 1974; Gioia & Chittipeddi 1991; Fairclough 1992; Weick 1993, 1995; Chikudate 1999a, 1999b; Wright et al. 2000; Brown & Humphreys 2003). Sense-making processes shape, and are shaped by, ‘events’ as well as the wider horizon of the ‘life world’ (Habermas 1984) from which events and sense-making processes emerge. The life world is the taken-for-granted background of routines, interactions, values and skills which are essential to the conduct of actors’ everyday affairs (Wright et al. 2000). The notion of sense-making and the constructs of routines are further defined in the following subsections.

2.5 Sense-making

Sense-making refers to those processes of interpretation and meaning production whereby social actors interpret phenomena and produce inter-subjective accounts (Wright et al. 2000; Brown & Humphreys 2003; Maitlis 2005). It is about ‘reality’ construction and it is the outcome of actors’ ongoing attempts to create order and make retrospective sense of what occurs (Weick 1993, 1995; Weick & Quinn 1999; Wright et al. 2000). Social actors, and organisations, absorb new information, and
reprocessed information. They assimilate it, through sense-making, into knowledge stores, such as organisational routines and rules (Johnson, Ravipreet & Rajdeep 2004) and cognitive maps (Axelrod 1976; Ranson et al. 1980).

The forming of interorganisational relationships is a complex change ‘event’ in which actors who have different understandings of themselves and their organisations, often are metamorphosed (Brown & Humphreys 2003). Further, interorganisational relationships are not discrete episodes but are ‘ongoing, evolving, and cumulative’ (Weick & Quinn 1999, p. 375). ‘Sense-making is about contextual reality. It is built of vague questions, muddy answers, and negotiated agreements that attempt to reduce the confusion’ (Weick 1993, p. 634).

Actors in an interorganisational relationship setting reflexively identify, sift and consider the relevance of past experience. This suggests that making sense of the new social context, while simultaneously working within the existing continuing (institutionalised) one, will be subject to constraining and enabling structures. Weick’s (1993) analysis of sense-making in the Mann Gulch disaster, and Chikudate’s (1999) analysis of sense-making and reflexivity in collaborative relationships between US and Japanese researchers in the pharmaceutical industry, offer two useful interpretive analyses of sense-making in altered contexts, when failure to adapt institutionalised ways of behaving threatened lives on the one hand, and interorganisational relationship effectiveness on the other.

More recently, Maitlis (2005) has undertaken a two year study of sense-making in three British symphony orchestras to identify patterns of accounts and actions among diverse stakeholders in their daily work lives. Using formal, semi-structured interviews, and observations of meetings, rehearsals and orchestra tours Maitlis constructed and analysed narratives that chronicled the sense-making activities associated with more than one hundred issues across the three orchestras. Amongst the stakeholder groups Maitlis identified ‘sensegiving’ behaviours by leaders, and other key actors. ‘Sensegiving’ behaviours were identified as those behaviours that attempted to influence the sense-making and meaning construction of other actors (Gioia & Chittipeddi 1991). Maitlis (2005, p. 44) described four forms of organisational sense-making, based on levels of control and animation, to describe
the different ways that heterogeneous parties interact in ongoing, “ordinary” sense-making processes over extended periods of time’.

Sense-making is contextual and social. It is a process through which actors attempt to create order, or rationality, from discrepant observations, and social, interactive cues (Johnson et al. 2004). In part, it is a learning process wherein the absorptive capacity of the actor, or the organisation, influences the interpretation and processing of new information. Absorptive capacity describes how knowledge develops cumulatively and builds on prior knowledge stores (Cohen & Levinthal 1990). Knowledge resides in abstract structures (such as organisational routines) and in more explicit organisational structures (such as rules, policies and procedures). The following Sections 2.5.1 and 2.5.2 consider various organisational schema that embody structures as mediums that influence, and are influenced by, the actor’s sense-making.

2.5.1 Organisational Schema

Social interaction is the process via which the actor’s ability to absorb and think takes account of others, and also requires the actor to decide if, and how to fit, the actor’s activities to others. In part, it is a learning process wherein the absorptive capacity of the actor, or the organisation, influences the interpretation and processing of new information. Absorptive capacity describes how knowledge develops cumulatively and builds on prior knowledge stores (Cohen & Levinthal 1990). Whereas actors respond to signs unthinkingly, they often use symbols to communicate something about themselves in inter-subjective situations.

An actors’ sense of ‘self’ is a tension between how one might want to appear and how others might expect one to appear. Therefore, ‘self’ is the product of the interaction between the actor and the audience (Goffman 1959; Greenwald & Brecker 1985; Compeau 1994). Goffman (1959) understood the ‘self’ as a social product. The degree to which the actor was able to sustain a respectable self-image in the eyes of others depended on access to structural resources, and the possession of traits and attributes deemed desirable by the dominant culture.
Goffman (1974) and Gonos (1977) explored the notion of ‘frames’ and suggested that events, actions, performances, and ‘selves’ do not always speak for themselves but rather depend on framing for their meaning. All social experience is organised by frames which govern the subjective meanings actors assign to social events. Gonos (1977, p. 860) defined frames as:

not conceived of as a loose, somewhat accidental amalgamation of elements put together over a short time span. Rather [they are] constituted of [as] a set number of essential components, having a definite arrangement and stable relations. These components are not gathered from here and there, as are the elements of a situation, but are always found together as a system … In all this, frames are very close in conception to ‘structures’.

Frames are shared meaning systems about what actors see in their social world, and without which their world would be little more than a number of chaotic individual and unrelated events and facts. Frames provide a basis for actor’s conceptual systems, the way they think, act and perceive reality (Conlon 1999). The way actors, and others, relate to the activity depends on the way it is framed (Ashforth & Kreiner 2002).

Social structure and social organisation may constrain the framing of experience in everyday social situations (Goffman 1974). Events may be interpreted according to one of three primary frameworks: natural, social or institutional. Events interpreted according to natural frameworks are perceived as unguided and not subject to moral judgment (for example, earthquakes). Actions interpreted according to social frameworks, on the other hand, are described as ‘guided doings’ and are subject to social appraisals (Goffman 1974). ‘Keying’ (Goffman 1974), or ‘normalising’ (Ashforth & Kreiner 2002), may transform the meaning of an activity from what it literally appears to be to something else. For instance, an utterance may be taken as a genuine expression of a person’s thoughts and feelings or it may be ‘keyed’ as sarcasm, or some other organisationally valued emotion. A design or a fabrication is an ‘intentional effort of one or more individuals to manage activity so that a party of one or more others will be induced to have a false belief about what it is that is going
on’ (Goffman 1974, p. 83). Unlike keyings, fabrications are intended to induce a false sense of reality and are subject to discrediting (Goffman 1974).

Judgments of character are particularly subject to framing because ‘self’ is not a stable substance. Not only are actors’ ‘selves’ a product of performances, but actors’ actions and performances do not always speak for themselves. A ‘self’ is not simply a product of performance, but is a product of the framing of an actor’s actions and performances. This provides the opportunity to create multiple realities each with its own logic and principles of organisation. Clearly in the context of this research involving observation there will be a question around the assessment of reality – just what has been heard, observed, measured and recorded? Is the researcher’s reality shared by other participants in the interorganisational relationships? How might this reality have changed if new interactions and participants were introduced? How might this reality change over time? How close is the presented, or observed, ‘self’ to the ‘real self’, or has the ‘self’, been managed? Sense-making may be influenced by actors’ framing of themselves and the interplay of experience, emotion and interaction. In all of this, sense-making emphasises that actors try to make things rationally accountable to themselves and others (Weick 1993).

There is an area of study about the cognitive schema that informs behaviour and routines appropriate in particular contexts. This has been called ‘scripting’ (Gioia & Poole, 1984; Pool, Gray & Gioia 1990; Barley & Tolbert, 1997; Johnson, 2000). Scripts underlie observable patterns of interaction between people in particular organisational settings. Scripting occurs over time and becomes integrated with institutional templates for acceptable behaviour. These behaviours may even be associated with more ‘formal’ structures that also result in legitimising behaviours, such as monitoring and recording for quality accreditation and registration by externally recognised institutions within the hospital sector. In less formal, daily contexts, monitoring and reporting on financial performance, responding to patient’s pain, a fall, or a family complaint, may take precedence over other behaviours if this behaviour has been sanctioned and legitimised by an organisation’s leadership. In the Hospital context narratives were often used to shape organisational life (Brown & Kreps 1993; Brown 1998) such as in the Hospital’s institutional script about ‘patient focussed care’. All employees were scripted to this construct through a managed
change process in the 1990s and subsequently through induction process for new employees, through conversations and organisational narratives led by the Chief Executive, and through regular referencing to the Hospital’s logo which embodied the construct in its design. The Hospital distinguished itself from others in the sector on the basis of this script.

Over time, employees experiment with both institutional templates and script revisions and eventually adopt the new scripted behaviours as the experimental behaviour is legitimised and reciprocated. This may occur at different rates and with different levels of commitment within the organisation. A failure to respond to the re-scripting process may compromise implementation of the change. Studies of change management suggest that strong leadership and prolonged organising effort will reshape institutionalised norms, scripting and stakeholder behaviours. ‘For de-institutionalisation to occur ‘taken for granted’ characteristics must be challenged. Indeed, cognitive processes must be put in place that are the reverse of those that led to institutionalisation in the first place’ (Johnson 2000, p. 5).

The notion that social actors construct their own version of ‘reality’ is consistent with the interpretivist perspective. Further, there is the basic idea that social actors engage in on-going sense-making to construct contextual reality and that this reality is sensitive to their need to maintain order, and traditions.

2.5.2 Routines

Organisations are characterised by routines and rules. Routines have been identified as the things that organisations do most (March & Simon 1958; Cyert & March 1963). Feldman & Pentland (2003) defined organisational routines as the repetitive, recognizable patterns of interdependent actions, carried out by multiple actors. Routines, however, are not mindless but ‘effortful accomplishments’ & Rueter 1994) and they may be adaptive and evolutionary (Cyert & March 1963; Baum & Singh 1994; Feldman 2000; Feldman & Pentland 2003), as in the establishment of an organisation.
Routines are also social phenomena that embody a duality of structure and agency (Bourdieu 1977, 1990; Giddens 1984). Latour (1986) and Weick (1993) distinguished two related parts in organisational routines. One part embodies the abstract idea, or meaning of the routine (structure), and consists of interaction patterns that stabilise meaning by creating shared interpretive schemes. Weick (1993, p. 20) referred to this part as ‘configuration, contextual constraints, or a vehicle that embodies dominant meanings, refers to a framework of roles, rules, procedures, configured activities, and authority relations that reflect and facilitate meanings’. The other part consists of the actual performances of the routine by specific people, at specific times, in given places (agency and therefore subjectivity) (Feldman & Pentland 2003). The performative aspect of routines may be ‘guided’ by explicit rules that give the appearance of unity of purpose. Rules are created by powerful actors but may still ‘disguise’ structural tensions beneath the surface in adaptive contexts. Specific configurations of rules may provide the basis for patterns of behaviour that appear as ‘the way we do things at the Hospital’. In a more controversial approach feminist organisational analysis (Calas & Smircich 1996) has suggested that rule construction may result in gendering of organisations. While this may well be the case, gender is not the focus in this research.

Structure is a complex medium of control which is continuously produced and created in interaction and yet shapes the interaction. Structures are constituted, and constitutive, of interpersonal cognitive processes, power dependencies, and contextual constraints (Feldman & Pentland 2003; Ranson et al. 1980). Organisational routines have been used to account for organisational inertia and inflexibility (Gersick & Hackman 1990; Weick 1993; Weiss & Ilgen 1985; Chikudate 1999a, 1999b).

Managing interorganisational relationships is acknowledged to be hard and the failure rate is said to be high (Harrigan 1985; Hutt et al. 2000; Quinn 2000; Hitt et al. 2002). Classic management studies (Fayol 1916; Barnard 1938; Simon 1945; Chandler 1962; Cyert & March 1963; Learned, Christensen, Andrew & Guth 1969) focused on the internal co-operation and organisation in firms, as well as the managerial functions and processes therein (Mintzberg 1973; Hoskisson 1999). Traditional management descriptions describe a process that is downward and outward. The organisational forms which result from relationships and networks require specific managerial
capabilities that are collaborative and emergent (Mockler 1997) rather than controlling (Useem & Harder 2000; Lasker et al. 2001; Linder, Jacobson, Breitfelder & Arnold 2001; Linder, Cantrell & Crist 2002; Hunter & Healy 2002). Organisations sometimes recognise these new capabilities by establishing new structures within organisations to oversee interorganisational relationship arrangements. ‘Strategic services’ divisions, ‘shared services’ units, ‘contracting’ departments, contract managers and relationship managers are some of these.

Early work on inter-group relations showed how the negative consequences of competition give way to the problem-solving benefits of co-operation when the conflicting groups can agree on subordinates’ goals (Pearce 2001). Hutt et al. (2000) in their study of Fortune 500 companies distinguished three levels of management involvement in relationships. Figure 2-4 shows that at each of these levels there are three routines which are seen as being fundamental to interorganisational relationship formation.

**Figure 2-4 Managers’ Involvement in Interorganisational Relationships**

<table>
<thead>
<tr>
<th>Top Level Managers</th>
<th>Develop broad goals and monitor progress. Signal importance of the interorganisational relationship. Provide ongoing backing and support.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle Management</td>
<td>Develop plans for joint activities.</td>
</tr>
<tr>
<td>Operational Personnel</td>
<td>Carry out the daily work of the interorganisational relationship.</td>
</tr>
</tbody>
</table>

*Source: Hutt et al. (2000)*

Findings from the study by Hutt et al. (2000) suggested that the following actions were important to interorganisational relationship functioning:

- Communication and information processing.
- Building trust between the parties through open and prompt communication, frequent interaction, timely exchange of information and feedback on each partner’s actions.
• Building a shared understanding of goals and common agreement on norms, work roles.

Hutt et al. (2000) further proposed that the following routines were important in developing the social fabric of the interorganisational relationship:

• Balancing the formal, legal procedures, and the informal, interpersonal processes.
• Encouraging early positive exchanges because these initial exchanges form the foundation for the relationship.
• Maintaining continuity of key personnel involved in creating the interorganisational relationship through to the execution to maximise commitment, understanding and knowledge. This is also supported by later empirical work by Johnson et al. (2002) on procedural justice and commitment in international joint ventures.
• Resolving difficulties and providing for evolution of agreements.
• Moving relationships from the formal role to the personal (qua persona).
• Ensuring visible participation by senior executives. One of the key purposes of this is to stimulate/lead the identity forming process for the interorganisational relationship in the organisation.
• Regularly auditing the evolving social, work and communication ties to gauge the health of the interorganisational relationship.
• Managing information flows.

Routines have an inherent dynamism and as such have the capability to generate change, merely by their ongoing performance. Meta-routines like business planning (Oakes, Townley & Cooper 1998, continuous improvement and total quality management (Hackman & Wagerman 1995) have been used as a means to generate change. The introduction of service delivery using an interorganisational relationship strategy contributes to development of is a meta-routine and perhaps formal rule that have the capacity to generate organisational change.
Managers of interorganisational relationships go beyond this to involve boundary spanning processes and flows that integrate and join what has normally been separate. Lasker et al. (2001) and Gray (1989) identify collaboration as the important management in these contexts. Collaboration is the process through which the combined different perspectives and resources of groups of people explore and construct solutions that go beyond their own limited vision of what is possible. Rules about autonomy and accountability are blurred against the more traditional management model. Interpersonal transactional processes count for much more in the success of outcomes. Management is ‘lateral’ more than downward (Useem & Harder 2000).

Whatever the type of interorganisational relationship, the objective of an organisation will be to have competent management oversight of its relationships. Managers, who can lead the repetitive interactive routines at the level of consciousness, over time and space, contribute to the production of social relations and the construction of effective interorganisational relationships (Boucher 2003). This competence will be reflected in which partner gains authority in the relationship. Lei & Hitt (1995) also suggested that short tenure of alliance managers negatively affects the development of managerial skills in the alliance and therefore performance by the partner. Further, alliance managers with short tenure do not contribute much managerial efficiency, because the valuable assets of informal understanding and psychological contracts between managers from both sides are not given the time to grow (Ring & Van de Ven 1992).

Organisational routines are reflexively constructed because they are commonly perceived as re-enacting the past. The performance of routines also involves adapting to changes in context. This requires either idiosyncratic, or ongoing, change as well as reflection on the meaning of actions for future realities. In organisations, events may occur that are perceived as ‘shocks’ by actors. Such shocks stimulate sense-making (Wright et al. 2000). ‘Events’ are critical occurrences, or decisive moments, in actors’ experiences that become turning points for sense-making. Actors reflexively monitor their experience and, thus, remake and recreate that experience (Emirbayers & Mische 1998).
Organisational behaviour researchers have also begun to recognise that emotions impact on daily work life and that the performative aspect of routines may be affected by emotions. Some organisations, such as those in the airline industry, also have explicit rules to guide emotion management (Diefendorff & Gosserand 2003; Goleman 1995, 1998; Hochschild 1983; Scott-Ladd & Chan 2004). Hochschild (1983, p. 7) developed the notion of emotional labour as ‘the management of feeling to create a publicly observable facial and bodily display’ while Diefendorff & Gosserand (2003) conceptualised that emotional labour management was guided by display rules and regulation strategies (Grandey 2000) which organisations specify.

Employees’ felt emotions, and displayed emotions, may be effected by situational sense-making influences (Rafaeli & Sutton 1989; Morris & Feldman 1996; Diefendorff & Richard 2003) such as their capacity or willingness to accept display rules, or adopt regulation strategies, to affect observable behaviours. Researchers have explored the relationship between specific organisational emotional display rules and employee motivation (Bechara, Damasio, Trmel & Damasio 1997; Grandey 2000; Ryan & Deci 2000; Diefendorff & Gosserand 2003), the effect of anticipated and unanticipated affective workplace events on actors’ sense-making and behaviours (Goleman 1995, 1998; Mayer & Salovey 1997; Lord & Harvey 2002; Pellitteri 2002), discrepancy monitoring by actors in interpersonal interactions (DeShon, Brown & Greenis 1996), and the use of emotion regulation strategies on cognitive change processes, that is, changing display standards (Mayer & Salovey 1997; Diefendorff & Gosserand 2003).

Grandey (2000) and Diefendorff & Gosserand (2003) argued that emotional labour is beneficial to organisations’ achievement of their objectives. This conceptualisation has application in the interorganisational relationships forming processes which involve high levels of social interaction, and sense-making, between client and provider actors. Successful emergence of the interorganisational relationships will be associated with constructive interactions, related to increasing reductions in actors’ sensed discrepancies between antecedent emotion display rules and actual emotion displays. The dynamic, interactive and temporal dimensions in relationships between emotions, rules and routines, have led some researchers to use learning as a
framework with which to examine the construction of organisational knowledge stores (Feldman & Pentland 2003).

Sense-making and structuring are, thus, complex dynamic concepts and the process of forming interorganisational relationships bring them into highlight. Client managers engage in purposeful activity to form interorganisational relationships with business partners. This purposeful activity is embedded in the concept of organisational routines but also must not be seen to be static. Rather it is a dynamic multi-faceted process of organising. To further the discussion of interorganisational relationship formation, the social interactive process of organisational schema is considered below.

Sections 2.3 to 2.5 have presented the notion of organisation as a socially constructed process. This conception provides a basis for considering interorganisational relationships at the Hospital as the constructed realities of managers and other actors, who, through socially interactive sense-making processes contribute to their forming. The interpretive perspective adopted in this research focuses on the interplay of context and social interaction in the emergence of organisational structures in a dynamic transformational process. Section 2.6 presents a summary of other relevant themes from the organisation research that may contribute to understanding about interorganisational relationship formation. While presented separately for ease of discussion, it is simultaneously acknowledged that the evolution of organisations is complex and integrative. No one influence or attribute alone describes the whole story.

2.6 Other Relevant Findings about Interorganisational Relationships

When there is continuing and purposeful co-operation by organisations across ‘boundaries’, different contexts are created for actors to manage. This section alerts the reader to other streams of research where knowledge developed might usefully be applied in more detailed investigation using the interorganisational relationship context. Extant literature on organisations and interorganisational relationships in particular, indicates that researchers have drawn upon theory, and applied methodologies, that are from both the positivist and the constructivist perspectives.
The following sections serve only to highlight some streams of research that have investigated influences on the character of organisations and the social interactions of actors involved in their formation, in their processes and systems of work, and in service delivery to others. The section ends with a summary of key organisation contextual influences that have emerged from the research literature.

2.6.1 The Notion of ‘fit’ between Organisations

At the individual level, a leader or manager uses cognitive structures to make sense of contextual attributes to construct and reconstruct ‘reality’. Organisational routines emerge over time and may become so institutionalised that other actors adopt such routines as ‘practices’ or ‘the way we do things here’. The ‘way we do things here’ is an expression of an actor’s perception of ‘fit’, congruity with, or ‘distance’ between, the culture, or sub-culture, of the organisation with which he or she ‘feels’ a sense of belonging or community. The role of interorganisational relationship managers may be to shape stakeholders’ expectations so that strategies and structures achieve a fortuitous ‘fit’ (Leonard-Barton 1992).

Research that examines the effect of cultural differences contributes most to understanding how such differences impact individuals’ decision-making behaviour and interorganisational functioning (Carlson 1975; Beamish, Killing, Donald & Allen 1994; Shane 1995; Yan 1998). Li et al. (2002) pursued earlier work by Yan (1998) on the study of the effects of cultural diversity and distance on behaviour. They found that small cultural distance minimised inter-partner conflict and enhanced trust between parties in international joint ventures. Others have explored these effects on top management teams (Jackson 1992; Knight, Pearce & Smith 1999). Findings that suggest managers’ decision making can be positively or negatively affected, depending on the extent of cultural distance between collaborating members of organisations, can also be interpreted within a sense-making framework. Member diversity may lead to a tension, even a disconnect, that in turn increases the likelihood of ‘events’ happening that stimulate active sense-making and re-interpretation of institutionalised practices or routines. In the context of interorganisational relationships, collaborating members who possess different, ‘antecedent cultures’
(cultural distance), may experience social conflict that stimulates sense-making to construct innovative routines and structures.

The aggregate of social practices, feelings, beliefs and values, routines and assumptions points to what other researchers refer to as organisational culture. Schein (1996) defined culture in terms of the beliefs and shared assumptions that underlie behavioural responses to organisational issues and problems. Over time these assumptions and beliefs become embedded in an organisation and make patterns of behaviour almost predictable. An organisation’s culture comes to be expressed through the actions and social practices of its members. New employees adopt these norms and values as the only way to perceive, respond and select actions in relation to external and environmental issues.

Some culture research developed a focus on the congruence, or ‘fit’, between the person and the environment over time and aimed for an understanding of the assumptions and individual meanings underlying the organisation and members’ points of view about their organisation or social setting (Damanpour 1991; Achilles 1999; Piderit 2000). The notion of ‘fit’ is a dynamic one and not meant to suggest any sense of rigidity. Rather it is a variable, dynamic notion and contextual and subject to a variety of interpretations by different actors. Lasker et al. (2001) and Lasker & Weiss (2003) referred to relationship “synergy” as the proximal outcome of relationship functioning in which the perspectives, resources and skills of a group of people, and organisations, contributed an advantageous fit to create a unique, effective relationship. When interorganisational relationships achieved synergy they derived strength and a capacity to break new ground, challenge accepted wisdom, and derive new solutions to problems.

Managers adopt and lead by these values and norms because they assume a responsible guardianship of these systems. Norms create expectations of behaviour that may underpin the way relationships should operate (Hofstede, Neuijen, Ohayv, & Sanders 1990; Lasker & Weiss 2003; Kern & Blois 2002). A leader’s orientation may affect sense-making and contribute to change rules and routines so that new practices develop. It has been recognised that agreement to a set of operating norms, and other such intangible connections as qua persona relationships, provide alternative forms of
governance to formal legal contracts. Norms and relationships may provide effective vehicles for flexibility in interorganisational relationships (Artz & Brush 2000; Kern & Blois 2002).

In their roles as agents for their organisations, leaders and managers may become the ‘protectors’ or, the builders, of culture. This is particularly so with interorganisational relationship-construction where the cultural interface between partnering organisations is open to new sense-making and culture construction. Social network researchers view such interfaces as providing opportunities for knowledge flows between organisations and individuals, but also for resistance and inertia. Learning has been shown to occur when partners are ‘culturally aligned’ and share the same assumptions about the purposes and goals of interorganisational relationship (Inkpen & Beamish 1997), and when all parties work together to avoid the ‘us’ versus ‘them’ situation that can lead to polarisation. Co-operative behaviours and ‘enculturation’ of new organisation members (Harrison & Carroll (1991, 1998), together with an organisation that has high ‘plasticity’ (Fox-Wolfgramm, Boel & Hunt 1998) and ‘absorptive capacity’ (Cohen & Levinthal 1990) have been shown to adapt to the type of change that accompanies the formation of interorganisational relationships.

Stakeholder researchers (Hill & Jones 1992; Preston & Donaldson 1999; Barringer & Harrison 2000) have explored the role of groups, and subcultures, within organisations. Stakeholders can affect, or are affected by, the organisation or interorganisational relationship. In a hospital they may include investors, governments, doctors, patients, families, employees, external providers, the local community, health insurers, and regulatory authorities. Stakeholders have tacit and explicit understandings with their organisation and, over time, identify with groups and organisations (Riordan & Vandenberg 1994). The concept of organisational identification comes from social identity theory. Organisational identification occurs when individuals identify themselves by the same attributes that they believe define the organization (Dutton, Dukerich & Harquail 1994). This suggests that the more strongly actors in an interorganisational relationship identify with an interorganisational relationship the greater will be their commitment to the business strategy. Maintenance of support, and the continuing alignment of interorganisational relationship members with parent organisations, has been shown to improve the
functioning of interorganisational relationships (Johnson et al. 2002; Jimenez & Pasquero 2005; Steensma, Tihanyi, Lyles & Dhanaraj 2005).

In a study of international joint ventures, Johnson et al. (2002) found evidence that alignment to common goals by the parent organisations and the international joint ventures were important to the international joint ventures achieving the business goals. Related studies (Korsgaard, Schweiger & Sapienza 1995; Sapienza & Korsgaard 1996; Smith, Collins & Clark 2005) have identified the importance of senior management team involvement in supporting, sharing and exchanging knowledge with interorganisational relationships members involved in their construction and maintenance. These studies found a strong correlation between procedural justice in strategic decision making and the level of decision control, perception of support, and interorganisational relationship level of commitment.

Managing the alignment and enculturation of stakeholders, or actors, in an interorganisational relationship is a challenging and dynamic process involving ‘layers’ of sense-making and sense-makers. Managers and their employees come and go over the life of an interorganisational relationship. Differences in managers’ and other stakeholders, prior experience, training and capabilities, orientation, involvement in decision-making, and length of tenure are all likely to impact their level of commitment (Johnson et al. 2002) and their adaptive sense-making (Weick 1993, 1995). Organisational learning research suggests that, in the context of interorganisational relationships, diverse-partner experience and partner-specific experience may contribute to alliance performance (Hoang & Rothaemel 2005). Researchers have made reference to the contribution of prior alliance experience in subsequent alliance formation although these data have not been presented to suggest that prior experience will contribute to greater success in partnering (Parkhe 1993; Stuart 2000; Gulati 1998; Hagedoorn & Schakenraad 1994). Interorganisational relationship management competency is, thus, recognised as fundamental to interorganisational relationship success.

Within the broader study of organisational culture and change some researchers have focussed on the processes of adaptation and resistance to change (Schumpeter 1942; Kraatz 1998; Levinthal 1994). In a survey of United States government executives,
internal resistance was identified as an obstacle to outsourcing success (Hunter & Healy 2002). Constructing the meta-routines of interorganisational relationship management comprise a fundamental structural and behavioural change for organisations. Oakes et al. (1998) explored coercive change associated with business reengineering in their study of the introduction of business planning principles into Canadian museums. Business planning was viewed as a mechanism of control, a pedagogic practice that fundamentally changed organisational identities by changing what was at stake. This work offers some parallels with the use of outsourcing and services partnering to affect business performance improvement.

In another study, Fox-Wolfgramm et al. (1998) undertook a longitudinal study of change in two United States banks following the Community Reinvestment Act. They drew upon typologies developed in Greenwood & Hinings (1988) who defined prospector and defender strategic orientations for organisations. One of the propositions that emerged from this study was that successful and sustainable change was more likely to occur when there was congruency between an organisation’s identity and image and the nature of the intended change. When the proposed change was perceived to have a behavioural synergy with existing behaviours, then it was more likely to be embraced. Fox-Wolfgramm et al. (1998) also associated the plasticity of an organisation’s identity and image, and its capacity to adapt to incremental, rather than punctuated change in its environment. In the context of interorganisational relationship management it may be that managers who display high levels of adaptive capacity will influence the overall functioning of the interorganisational relationship. This notion of incremental change and adaptation is consistent with iterative behaviours and contextual changes identified by Ring & Van de Ven (1992).

One further aspect of the plasticity of an organisation’s identity emerges from the notion that organisations grow as a measure of the extent to which they satisfy stakeholders, even though such stakeholders may have multiple and conflicting criteria for assessing organisations. Interorganisational relationship managers face competing and paradoxical requirements. The test of a first rate leader or organisation may be the ability to exhibit contradictory or opposing behaviours (as appropriate or necessary) while still maintaining some measure of integrity, credibility and direction.
Organisations with high degrees of plasticity may be better able to do this and satisfy the multiple competing demands of their stakeholders (Denison, Hooijberg & Quinn 1995).

There is an inherent tension for managers and actors working in an interorganisational relationship context within a much wider organisational context, such as can be created when an organisation decides to outsource services, or to form a joint venture, for example. The traditional routines and practices that ‘work’ in one context may not ‘work’ in another. There may emerge a tension between an organisation’s need to ‘control existing operations’ and the need to create an environment which will permit new ideas, and new knowledge and practices, to flourish. For actors and managers it may be the situation that old ways of doing things need to die a timely death. ‘Cultural lock-in’ or the inability to change the corporate culture even in the face of clear market threats has helped to explain why some organisations have found it difficult to respond to the need for change. Cultural lock-in results from the gradual stiffening of the ‘invisible architecture’ of the corporation and the ossification of its decision-making abilities, control systems and mental models (Axelrod 1976; Senge 1990).

Interorganisational relationships bring into focus the ‘fit’ between stakeholder groups in organisation construction. Organisations contribute to build individual actors’ identities, perspectives, and thus their sense-making processes, in ways that may impact on their behaviours in constructing new forms of organisation, such as interorganisational relationships. Individual frames and extant scripts reflecting institutionalised organising practices, often based on power and control, may be found less appropriate in interorganisational relationship contexts where collaboration and stewardship may better help to construct the new organisation. A deeper understanding, and integration of knowledge about individual cognitive structures and processes within organisation culture, together with its influence on adaptive behaviours may further understanding about how interorganisational relationships emerge and how managers contribute in this process.
2.6.2 Building Relational and Social Ties

There is a stream of research by organisational sociologists examining factors that explain the form and structure of interorganisational relationships. Ring & Van de Ven (1992), as well as Boddy et al. (2000), suggest that co-operative relationships develop as parties negotiate commitments for future action. Relationships emerge through an iterative, evolutionary process and reflect the experiences of individuals and their exposure to organisational events.

Ring & Van de Ven (1992) used structuration theory (Goffman 1959, 1974; Giddens 1984), while Smith (2005) used social systems thinking, to conceive the organisation process as an evolutionary one, involving social interaction between individuals within role and personal dimensions, and operating at operative, management and executive levels within and between organisations. The proposition has been developed that through these interactions mutual respect, trust and understanding develops, new contexts are created and evolved, and these strengthen connections between actors and organisations. Interorganisational relationships are, thus, socially emergent and adaptive.

Relationship longevity is achieved through a fine balance between formal and informal interactions (structure and processes) built around levels of commitment, compatibility, and trust (Zaheer & Venkatraman 1995; Hutt et al. 2000). Boddy et al. (2000), building on the work of Doz (1996) and Ring & Van de Ven (1992), described the process of partner formation using an interactive social change framework. This structuration model was adapted from Orlikowski (1992) and was used to explore how the business context provided for certain behaviours which in turn, through interaction and the social reconstruction of key stakeholders, re-contextualised the business environment to shape a change of mutual benefit. When this change in behaviour became habitual, it ultimately institutionalised and was embedded in ways that supported the interorganisational relationship.

These empirical studies illustrated the evolutionary nature of partner formation and focused on the important role of individuals in interorganisational relationship functioning. The findings by Boddy et al. (2000) and Hutt et al. (2000) support earlier
propositions by Ring & Van de Ven (1992) who observed that as an interorganisational relationship evolved, personal relationships \( (qua\ persona) \) increasingly supplanted formal role relationships, and informal psychological contracts increasingly substituted for formal legal contracts. This suggests that managers, and others involved in interorganisational relationship implementation, will attempt to establish relationship-forming behaviours as a priority.

2.6.3 Trust and Governance

Trust is the willingness to accept vulnerability based upon positive expectations of partner behaviour (Hutt et al. 2000). Trust emerges over time from the repeated interactions between personnel in the relationship (Ring & Van de Ven 1992, 1994; Narayandas & Rangan 2004). Ring & Van de Ven (1992, 1994) identified interpersonal trust as an emotional response between parties that developed as the partnering process took place. Jeffries & Reed (2000) called this ‘affect-based trust’ as it was based in a tacit and reciprocated belief between the parties, founded in a mutual concern for the well-being of the other, emotional attachment, and friendship. Ring & Van de Ven (1992) identified the development of trust with a change from role, to \( qua\ persona \) relationships, or interpersonal trust rather than organisational trust.

Management research on organisational level trust suggests general agreement that it is beneficial for performance. Interorganisational relationship researchers have examined the relationship between trust and governance practices (Gulati 1995a, 1995b; Dyer & Singh, 1998; Hoecht 2002; Subramani & Venkatraman 2003). Where the level of investment in a relationship is high organisations will try very hard to exercise authority and try to have its people in the position of relationship manager (Das & Teng, 1998b). Some equity relationships utilise governance mechanisms, often referred to as ‘hostages’, wherein partnering organisations place their own resources on each other’s governing bodies. Formal governance mechanisms, such as contracts, agreements and performance monitoring mechanisms for accountability are traditionally used in interorganisational arrangements. There is much in the more popular literature about the importance of these mechanisms for buyer ‘protection’
(Hutt et al. 2000; Hunter & Healy 2002). The need to balance the formal governance mechanisms with trust-based adaptive behaviours that recognise the need for change and variation has also been identified. It has been suggested (Dyer & Singh, 1998) that over-monitoring may contribute to a reduction in trust between partners, the consequences of which is a less effective functioning relationship.

The results on interpersonal level trust are less clear. Relationships between partnering organisations are not optimal when both organisational and interpersonal trusts are high, or both are low (Jeffries & Reed 2000). Jeffries and Reed suggest that here is a downside to such levels of trust expressed through reduced motivation leading to complacency and negatively affecting performance. Some researchers (March & Simon, 1958; Das & Teng, 1998a, 1998b) have cautioned against the development of high levels of interpersonal trust and affect based trust, suggesting that a degree of tension in the relationship is more likely to contribute to cognitive-based decision making. Such decisions will avoid the non-rational, non-economic and scripted decisions of affect-based behaviours. The co-incidence of high organisational trust and low cognitive and low affect-based trust is best. High organisational trust between partners will improve joint planning, decision-making and communication (Hutt et al. 2000).

Das & Teng (1998a, p. 39) examined the presence of trust from a resource and risk management perspective. They concluded that interorganisational relationships would be more successful ‘if firms adopt an alliance making process that is based on a full appreciation of the types of resource and risk that determine the position of each partner in the process.’

Building trust and interpersonal relationships are key competencies for managers of interorganisational relationships. Trust is an emotion, and while rationality is bounded, the achievement of ‘productive’ trust through relationship management will require regular input by key personnel involved in the relationship, and by the interorganisational relationship manager who must co-ordinate, communicate and engage all stakeholders in the web of interactions. In the interorganisational relationship context, trust suggests that a partner’s actions will meet expectations, including the absence of opportunistic behaviour (Hitt et al. 2002, p. 29).
2.6.4 Client Orientation and Objectives

Purposefulness is a feature of interorganisational relationships. Actors in such organising forms are orientated to, or given direction by, organisational goals and objectives. Das & Teng (1998a) referred to ‘orientation’ as that aspect of an interorganisational relationship that a member views as its priority, and to which, it would devote most of its management effort such as, cost savings, profitability, customer service, technology utility, or knowledge transfer.

Various reasons have been cited for adoption of the interorganisational relationship strategy. Porter (1985, 1991) suggested there was much benefit to be gained by organisations co-operating rather than standing alone. Leveraging profitability by focusing on what the business does best was preferable and more sustainable. Recently, Hagel & Singer (2000) have noted the trend by organisations to ‘unbundle’ traditional business processes in a systematic drive to reduce interaction costs. As a consequence, economic associations with other organisations have been founded. This notion that reducing transaction costs associated with a business activity would enhance business performance was avidly conceived in Williamson’s (1985, 1991) transaction cost economic theory (1985, 1991) and adopted by others, such as Dyer (1997), to analyse the benefits of interorganisational relationships. Williamson (1985, 1991) developed the notion of transaction cost theory to explain the growth of large firms in exchange, sharing, or co-development capitalist economies. The vertically integrated structure of these large firms evolved as a result of the drive to minimise the cost of transacting between businesses in the value chain. Dyer (1997, p. 536) split transaction costs into, four separate costs, namely, search, contracting, monitoring and enforcement costs:

- Search costs include costs of gathering information to identify and evaluate potential trading partners. Contracting costs refer to the costs associated with negotiating and writing an agreement. Monitoring costs refer to the costs associated with monitoring the agreement to ensure that each party fulfils the predetermined set of obligations. Enforcement costs refer to the costs associated with ex post bargaining and sanctioning a trading partner that does not perform according to the agreement.
Dyer (1997) identified that for US firms, contractual governance mechanisms and asset specificity is associated with higher transaction costs than for Japanese firms. The latter appeared to engage in more integrated relationships with stronger relationship-based governance mechanisms. These findings suggested that the focus on minimising economic transactions alone is not adequate to ensure relationship performance and longevity. He suggested a balanced combination of controlled exchange, self-enforcing, trust-related governance, and asset specificity to enhance focus on transaction value rather than cost alone.

A further study by Stuart (2000) on the US semiconductor industry between 1985 – 1991 confirmed that organisations acquire economic advantage from collaboration with bigger, older and innovative alliance partners. Looking at sales volumes and patents, Stuart showed that the performance of smaller firms in the same sector was improved although he emphasised the importance of selecting partners with appropriate ‘attribute profiles’. Associations between organisations also provided other benefits, such as consumer and competitor recognition of an organisation’s connectivity to another highly valued firm. This association contributed to market endorsement and confidence in the smaller and younger organisations (Stuart 2000).

While transaction cost economic theory has a focus on the cost of transactions that occur from activity, another perspective, the resource-based perspective, emphasises the value of resources and suggests that these may be maximised through relationships (Van de Ven 1976; Doz & Hamel 1998; Das & Teng 2000; Miotti & Sachwald 2003). Eisenhardt & Schoonhoven (1996, p. 137) express the resources-based view as ‘co-operative relationships driven by a logic of strategic resource needs and social resource opportunities’. The resources-based view focuses on the importance of firm resources such as capital, financial markets, social assets, like competencies (knowledge stores), and their management for competitive advantage. These assets may be tangible and intangible. Strengthening these assets contributes to an organisation’s competitive advantage. Interorganisational relationships give access to valuable organisational resources (of the partner) that are scarce, imperfectly replicable, or lacking in direct substitutes (Barney 1991; Peteraf 1993). The resource-based perspective suggests that organisations conducting expensive, risky or complex research projects will seek research and development co-operation to enter new
product areas in sophisticated technology fields, for example in the biotechnology sector and the emerging multi-media fields (Miotti & Sachwald 2003).

In the public sector, government policy change, albeit driven by similar economic reasons, and accompanied by stronger political and community ideologies, has driven privatisation, contracting out and outsourcing strategies (Pollit 1993; Hodge 2000; Hunter & Healy 2002, 2003). Such strategies have resulted in new public and private business relationships (Brunsson & Sahlin-Andersson 2000). Property Rights theorists have conceptualised that activity, which is privately owned, is better run than when it is publicly owned. The transfer of an asset, such as competency, to new ownership improves tending to the asset and enhances its profitability and effectiveness. Privatisation, or outsourcing, then prepares an organisation for a buy-back arrangement wherein the reverse delivery is enhanced because of the rightful ownership of the transferred business activity. A mutual benefit accrues because of the rightful choice of ownership. This logic was well summed up by Starr (1989, p. 28):

The theory of property rights explains differences in organisational behaviour solely on the basis of the individual incentive created by the structure of property rights … Property rights, in this view, specify the social and economic relations that people must observe in their use of scarce resources, including not only the benefits that owners are allowed to enjoy but also the harms to others that they are allowed to cause. A right of ownership actually comprises several rights, chiefly the rights to use an asset, to change its form, substance or location, and to transfer all or some of these rights. Thus, the key issues for the theory are, first to whom are the property rights assigned, and, second, how, if at all, are they attenuated? The more individuals stand to gain from tending to their property, the better it will be tendered. Conversely, the more attenuated and diluted their property rights, the less motivated individuals will be to use property under their control efficiently.

Property theory has been used at the meta-analysis level to extrapolate the economic impact in the transfer of businesses ownership and generally been found to support improved business performance (Hodge 2000).

In contrast to the public and for-profit sectors, not-for-profit organisations have traditionally been associated with social or community goals. A short-term focus on
social projects and funding uncertainties have often contributed to organisational identities and cultures that may be different to the one orientated to security, profitability and growth. Not-for-profit organisations have been associated with an absence of the same level of rigorous scrutiny and accountability to external owners or shareholders that characterises the commercial organisations. The use of market driven, competitive metrics for performance comparison has not developed and organisational capabilities tend to reflect this. Hubbard (1997) examined this issue of performance measurement for different types of organisations. Chief executives of not-for-profit organisations identified customer satisfaction and quality improvement as the major measures of success followed by employment growth, asset size, asset growth, total sales and sale growth. Profit growth, and return on investment were the least utilised measures. The research literature on the not-for-profit sector is not as voluminous as it is for the commercial sector. The Hospital that is the subject of this research is a not-for-profit organisation and there is evidence in its operating reports that it reports regularly to its Board on financial performance as well as the more qualitative indicators. Without shareholders however, the financial emphases may be different.

Other reasons identified for interorganisational relationship formation have derived from the need to access new capabilities and technologies. Relationships between organisations enable knowledge to flow across ‘boundaries’ and for new knowledge to be constructed and ‘harvested’ (Miner, Amburgey & Stearns 1990; Dyer & Singh 1998; Snyder 1999; Bell, Giordana & Putz 2002). Such ‘harvesting’ occurs in the form of opportunities for innovation in product development, processes and systems, first-to-market advantages in high technology industries, and improvements to support services in non-core business areas of existing more traditional organisations (Burnett, Brookes-Rooney & Keogh 2002). This social learning perspective suggests that a focal organisation within a network can evaluate the adaptive behaviours of its peers and imitate those practices which appear to be beneficial and feasible in light of other contingencies it faces.

Researchers have explored relatedness as a social construct, giving rise to the concept of a ‘social network’ (Granovetter 1985; Gulati 1995a, 1995b, 1998; Lasker et al. 2001; Yli-Renko, Autio & Sapienza 2001). As alliances are essentially voluntary co-
operative structures, interaction between the multiple organisations results in flows of information, or resources, between members. These resources have been called ‘social capital’ and these attributes can become embedded within the network over time (Ring & Van de Ven 1992; Gulati 1998; Van de Ven 1976; Zollo et al. 2002). Gulati (1998) used a social network perspective to highlight that the social embeddedness of organisations in a network of external contacts or relationships can influence economic actions and performance. Resource dependency theorists acknowledge that social capital is an important differentiator among organisations and, in turn, a factor in organisational relationships. In one study of liberal arts consortia, Kraatz (1998) found those colleges that had strong ties and stable relationships tended to adopt professional programs that had previously been implemented by others in the same consortium. Adaptation, rather than imitation, was the result of high-capacity information flows within the network.

The construction of social capital through boundary spanning interactions between associating firms also emphasises the temporal dimension through which relationships evolve (Chikudate 1999a, 1999b; Johnson et al. 2004; Narayandas & Rangan 2004). In this way social network theory goes beyond the economic dyadic exchanges in transaction cost economic theory to contribute to knowledge about interorganisational relationship performance. Inkpen (1995) and Gulati (1998) are among researchers who have suggested that prior experience of managing in interorganisational relationships builds learning, and thus social capital, so that improved functioning of interorganisational relationships can be achieved. Social systems theory and the field of social interactionism (Giddens 1984; Goffman 1959, 1974; Zollo et al. 2002) provide worthy frameworks for analyses of the social interactions between partnering organisations that are the basis for communication and knowledge construction.

Within the interorganisational relationship field some researchers have examined the emergence and growth of interorganisational alliances using the institutional perspective. This perspective proposes that organisational practices and structures emerge and become established over time due to imitation and conformity (Osborn 1998). In cross boundary contexts choice and determinism about conformity of the new entity to its setting are characterised by greater uncertainty and ambiguity.
When organisations implement expansionist strategies that take them beyond their national boundaries they implicitly take with them cultural and socioeconomic choices. Often the absence of shared histories, leads one organisation to attempt to impose its system on the other (Whitley 1994). More recent findings suggest that interorganisational relationships have to overcome these contextual differences (Chikudate, 1999a, 1999b; Li et al. 2002). However, Denekamp, Osborn & Baughn (1997) find there is evidence to support the idea that certain forms of international alliances are more stable and able to influence their immediate environment than others. This institutional view suggests, therefore, that characteristics of interorganisational co-operation may conform to a type of industry embeddedness, based on collective learning and informed imitation (Osborn 1998).

Each of these perspectives contributes some understanding about why organisations seek to partner with others. These reasons, in turn, affect processes of interorganisational relationship forming and functioning. After the decision to initiate the interorganisational relationship, whether international or domestic, decision-makers must agree a ‘logic of association’ and a process of interaction. Sociable participants assume responsibility to construct the interorganisational relationship with this ‘logic of association’ in mind. Managers, and others, embark on this implementation, or construction process, in ways that reflect their own experiences, knowledge and interpretive frames. Accountability requirements and organisational objectives help to shape managers’ approaches to decision making and priority setting.

It is possible for managers of interorganisational relationships to be caught between their roles as ‘agents’ for their organisation and as relational manager with the partnering organisation (Johnson et al. 2002). Within the literature on public sector privatisation some of this resistance is expressed as a ‘managerial mindset’. Executives and managers act as agents in their organisations and their tendency is to a control-orientated management style (Winter, Sarros & Tanewski 1997). This may mean that creative new business ideas struggle to succeed. This is an impact of Managers’ who impose traditional financial screens when they sense that anything non-incremental is high risk (Hamel 1999). Wright (2000) and others (Tversky & Kahneman 1974; Schell 1991; Busenitz & Barney 1997) suggest there is evidence that
individual differences make it difficult for decision makers to change their decision mode. Wright (2000, p. 2) commented:

> Heuristics refer to simplifying strategies that individuals (e.g., entrepreneurs) use to make strategic decisions … Entrepreneurial cognition refers to the more extensive use of heuristics and individual beliefs that impact decision making. Managerial cognition refers to more systematic decision making, in which management uses accountability and compensation schemes, the structural coordination of business activities across various units, and quantifiable budgets to justify future developments.

This management response may affect the performance and success of the interorganisational relationship. A study of orientations, contexts and objectives is, thus, important in understanding the alliance making and management process.

The boundary spanning context of interorganisational relationships provides the ‘playing field’ for actors with different perspectives, identities and cultures. Such tacit knowledge legacies contribute to tensions that stimulate sense making and the process of reconstructing organisational behaviours. In a recursive way, social actors, draw upon their existing routine practices and knowledge stores, and over time, give rise to new social structures and systems, such as interorganisational relationships. The focus in this research is to trace what an organisation’s client managers do, as they make sense of higher level management decisions to construct co-operative working arrangements. In this research, the Hospital actors ‘inherited’ their Executive management’s decision to initiate interorganisational relationships. While the decision may have been top-down, the subsequent interactions taken during implementation may be seen as less rational, ‘satisficing’, highly interactive, incremental and iterative (March & Simon 1958; March 1989; Reed 1991).

In the following Section 2.7 the researcher adopts a structure model of interorganisational relationship implementation. This narrowing is for temporal scene-setting. Its purpose is to identify the period in the interorganisational relationships during which the management activity is the focus of this research. The decision to form an interorganisational relationship has been shown to be highly contextual, variable, often inconsistent, and externally driven (Reed 1991). Although this research focus covers the period of time after the decision is taken to form an
interorganisational relationship, the legacies of the pre-implementation period may influence the subsequent phases of interorganisational relationship formation.

### 2.7 Phases of Interorganisational Relationship Formation

Traditional management activity is portrayed as a predictive process wherein decision making and activity is directed downwards. This view tends towards a causal and hierarchical one wherein subordinate behaviours are predefined and prescriptive. This view of management practice fails to completely inform practice for the manager engaged in interorganisational relationships. The contextual influences in interorganisational relationship require that managers be more adaptive, collaborative and lateral.

Empirical research has been inclined to examine interorganisational relationships at a given time and then to attempt to project their trajectories (Narayandas & Rangan 2004). This research takes a different approach. By taking a longitudinal perspective it has been possible to view interorganisational relationships as dynamic, self-organising processes that emerge from the daily interactions of managers, and others. The research used an interpretive methodology and an auto-ethnographic method to study, over time, the evolution of six interorganisational relationships in a hospital context. The relationships were characterised by various degrees of initial asymmetry and have evolved in dramatically different ways over time.

Researchers have identified stages in the formation of interorganisational relationships of various forms (Parkhe 1993; Useem & Harder 2000; Goolsby 2002; Goolsby & Whitlow 2003; Narayandas & Rangan 2004). Figure 2-5 presents three general phases of interorganisational relationship formation. This is developed for the purposes of this research to ‘locate’ the phase of interorganisational relationship that is the focus of this investigation.

The *Initiation* phase is typified by early events and activities that articulate reasons and objectives for the interorganisational relationship. These may be, but not always, captured in formal documents such as requests for quotation, specifications, and tender documents. Further, there are key activities that involve searching and
selecting the right organisational partner. These activities are followed with negotiations and contract determination (Parkhe 1993; Useem & Harder 2000; Goolsby 2002; Goolsby & Whitlow 2003). In this research each of the six interorganisational relationships had moved beyond the initiation phase when the Manager took up her responsibilities for the relationships’ management. For this reason the focus of this research is on the Maintenance phase.

The Maintenance phase (Parkhe 1993; Narayandas & Rangan 2004) is about constructing and sustaining the interorganisational relationship. Some researchers refer to ‘functioning’ and collaboration (Gray 1989; Kreuter, Lezin & Young 2000.; Lasker et al. 2001). This is the construction phase during which social actors engage in boundary spanning interactions to build and that make interorganisational relationships work. This is the phase when the actors jostle, interact and learn about each other as they construct new routines and reconstruct old ones that will work to achieve the benefits identified in the strategic decisions to initiate the relationship formation. This is also the stage when actors weigh up the relative gains of co-operation against competition (Parkhe 1993) and when power relations, reciprocity and trust emerge to create and sustain the interorganisational relationship structure.

**Figure 2-5 Three Phases of Interorganisational Relationship Implementation**

![Diagram of three phases: Initiation (Foundation), Maintenance (Construction), and Termination (Decommission)](source: Developed for the research)

Phase three is called Termination and is associated with activity to deconstruct the relationship when the partners have decided to remove themselves from the relationship.
The focus in the research presented in this dissertation is on the *Maintenance* phase during which managers’ motivation is to construct and sustain the boundary-spanning organisation. Self-organising processes are associated with relationships building, knowledge sharing and construction of roles, rules, and routines for collaboration. Social interactions between actors spawn new activities and events that in turn yield further activities (Ring & Van de Ven 1994; Browning et al. 1995). This is also the phase when actors from different organisations make sense of their commitments to simultaneously achieve the strategic objectives of their respective organisations, as well as the needs in creating a new interorganisational form. This research will show that this challenge may also result in destructive behaviours when actors, faced with the challenge of creating a new ‘reality’, are not able to discard, or adapt, their traditional structures and structuring processes fail to establish new meaning.

### 2.8 Chapter Summary

This review of literature has drawn upon concepts and findings that inform the management of interorganisational relationships. Sense-making is a social interactive, process that occurs when managers, and others, collaboratively engage in self-organising processes within the framework of their responsibilities to change in their working environment. Through sense-making, managers attempt to ‘rationalise’ events around them, to retrospectively construct new realities and enable future actions. Sense-making is an interpretive process during which managers, and others, construct accounts that allow them to comprehend their world and act collectively (Maitlis 2005). Studies about sense-making have adopted cognitive foci (Dutton et al. 1994; Zollo et al. 2002) and others have examined the inter-subjective behaviours of those in crisis, or adaptive contexts (Weick 1993; Chikudate 1999a). This research builds further on these approaches by presenting an investigation of managers’ sense-making processes during the more daily implementation of interorganisational relationships in the setting of a hospital.

The interorganisational relationships strategy is spreading across industry sectors. To implement this business strategy, managers engage in activities and events that powerfully influence how interorganisational relationships emerge. As a result it is important to understand how social actors contribute to interorganisational
relationship formation. The way that the research exploration was conducted is explained in detail in the following chapter, prior to the presentation of the research findings in Chapters 4 and 5.
3 RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the interpretivist paradigm and the reflexive interpretive methodology together with the qualitative methods used in this research. This approach adapts methods from the disciplines of sociology, social psychology and anthropology to address the research questions. A tripartite model is outlined in Section 3.2. This addresses the interpretivist perspective, the methodology and the methods used, as well as the context of six interorganisational relationships at the Hospital. Section 3.3 addresses matters relating to the role of the researcher and some ethical issues raised by this. In Section 3.4 the process of enquiry is described in detail and the process of interpretation is considered in Section 3.5. Matters of trustworthiness in interpretive research are examined in Section 3.6 and the chapter ends with a summary in Section 3.7.

3.2 Tripartite Model for this Research

This section describes the tripartite model used in this research. The researcher adopted an interpretivist theoretical perspective which established a framework of assumptions to guide the research. The following Figure 3-1 describes this tripartite model.

Interpretivist research is derived from empirical materials (data) that emerge after the application of the interpretation method (Travis 1999). Figure 3-1 considers the expression of the interpretivist paradigm (the intellectual framework) through the methodology and the methods, and its application to this research about managing interorganisational relationships. Further discussion follows that elaborates this research approach.
3.2.1 Interpretivist Theoretical Perspective

Social science researchers approach the study of organisations with implicit and explicit assumptions about how social reality is perceived. These perspectives are described by a distinctive ontology and epistemology that drive the pursuit and construction of social knowledge. These underlying perspectives ‘persuade’ researchers to adopt a particular world view and influence their methodological approach in researching phenomena (Guba & Lincoln 1994).

The interpretivist research paradigm is described by a set of assumptions with regard to ontology and epistemology. These are outlined in Sections 3.2.1.1 to 3.2.1.2 as follows.

3.2.1.1 Ontological Assumptions

These assumptions relate to the phenomenon under investigation and centre on different views about the ‘reality’ to be investigated. On the one hand, there is a view that ‘reality’ is real and measurable (objective) and imposing upon the individual, because it is external to the individual. This is a positivist view of reality and it
contrasts with an interpretivist view which was adopted in this research. Ontological assumptions in interpretivism hold that reality exists in the form of mental constructs that are socially and experientially based, local and specific and dependent of their form and content on the persons who hold them (Travis 1999). Reality is, as a consequence, a construct of an individual mind.

Those who adopt the interpretivist perspective are critical of the positivist approach with its basis in notions about the universality of truth and ‘grand theories’ (Lyotard 1984; Calas & Smircich 1999; Alvesson & Skoldberg 2000). Interpretivists propose a more subjective approach to the production of ‘true’ knowledge and understanding of the world and reject the notion of a ‘real-world’ arguing instead that something may be experienced-as ‘real’ but that is not the same thing. They reject that phenomena are objective facts in some real world.

3.2.1.2 Epistemological Assumptions

Epistemological assumptions relate to a view about knowledge and how knowledge can be communicated. The interpretivist epistemology regards social scientific knowledge as being derived from everyday concepts and meanings; from socially constructed, mutual knowledge. ‘The social researcher enters the everyday social world in order to grasp these socially constructed meanings’ (Blaikie 2000, p. 116) and ‘works from a realised bias and connected ethical concerns’ (Travis 1999, p. 1042).

The interpretivist perspective recognises that the social actors, such as the participants within interorganisational relationships, construct their reality. The researcher and the participants make sense of social interaction within their shared context and they construct meaning and structures. New meaning, in turn, shapes behaviours and over time creates new knowledge and understanding, such as about the management of functioning interorganisational relationship phenomena.

Thus, Weick (1999) described meaning construction as an ‘inward’ looking process toward self reflection and interpretation. Individual’s sense-making helped to create
meaning in multiple and varied forms. Other earlier researchers had proposed that legitimate knowledge resided in ‘petit recits’, as in Levi-Strauss’s (1967) ‘patchworks’, or small narratives, and in ‘the small, the local, the fragmented, historically emerged, contradictory and accidental’, as referred by Alvesson & Skoldberg (2000, p. 161). Such narratives, or accounts, are capable of disappearing because they are temporary language ‘games’ between individuals. Tension, descensus and differences are irreducible elements of this game which aims at creative development (Alvesson & Skoldberg 2000, p. 162).

An interpretivist perspective is appropriate for this research because it aims to explore how managers made sense of, and constructed meaning and knowledge about how to work within the interorganisational relationships context. Their construction of their new ‘reality’ was made challenging by their concurrent perception of a wider workplace reality as in the Hospital that employed them. The next section discusses the reflexive interpretive approach that is advocated by Alvesson & Skoldberg (2000), Alvesson (2003), Klein & Myers (1999) and Cunliffe (2002).

3.2.2 Reflexive Interpretive Research Methodology and Methods

A reflexive interpretive research methodology (Alvesson & Skoldberg 2000) has been adopted. This reflects the researcher’s response to the previous assumptions, and where she placed herself on the continuum of orientation between beliefs about objectivity and beliefs about subjectivity. This researcher has attempted to understand her social world through first hand experience of the social actors themselves, and through her own immersion in the phenomena being explored.

The methodology has enabled meaning and knowledge to be emergent, so that it has been constructed and reconstructed over time as the researcher experienced her world. Positivists would argue against the notion that a researcher could exist ‘in-the-world’, on the grounds that the methodology ensures distance from the object under enquiry. Such distance is crucial to positivists’ notions of rigor, generalisation and verifiability. The idea is that anyone should be capable of replicating the study (Bassett 2004). However, this researcher rejects such positivist notions. Instead, she has embraced recursiveness, continuance and change as fundamental attributes and opportunities in
her exploration of her experience, her ‘reality’ construction, and in her personal learning, gained in large part through the auto-ethnographic method adopted.

Alvesson & Skoldberg (2000), and others such as Klein & Myers (1999) and Cunliffe 2002 as well as researchers in the health industry (Gergen & Gergen 1991; Koch & Harrington 1998; Johns 1999; Mulhall 1999; Freshwater & Rolfe 2001) argue for a multi-layered reflexive interpretive approach. This approach is discussed in the following section.

3.2.2.1 A Reflexive Interpretive Approach

The reflexive interpretive approach sources its inspiration in the complex relationship between processes of knowledge production and the various contexts of such processes, as well as the involvement of the knowledge producer (Alvesson & Skoldberg 2000, p. 5):

Serious attention is paid to the way different kinds of linguistic, social, political and theoretical elements are woven together in the process of knowledge development, during which empirical material is constructed, interpreted and written. Empirical research in a reflective mode starts from a sceptical approach to what appear at a superficial glance as unproblematic replicas of the way reality functions, while at the same time maintaining the belief that the study of suitable (well-thought-out) excerpts from this reality can provide an important basis for a generation of knowledge that opens up rather than closes, and furnishes opportunities for understanding rather than establishes ‘truths’.

In her reflections about the state of management learning, Cunliffe (2002, p. 35) also proposed the greater use of ‘a reflective/reflexive dialogue in which participants connect tacit knowing and explicit knowledge … and take a critical view of their dialogical practices and what may constitute “good” learning conversations’. She argued that the reflexive interpretive approach offered opportunity for more depth in meaning construction than that derived only from reflex interaction which characterises the ‘instantaneous, unselfconscious reaction in-the-moment dialogue that characterises much of our experience’ (Cunliffe 2002, p. 49).
The researcher has attempted to use reflexive dialogue in a multi-layered way. This enabled the researcher to question her ways of understanding, being and acting in the world. In this way the researcher, (who was also the Manager), became aware of her assumptions and the impact they had on her thinking, acting and reality construction. This means that different levels of interpretation are reflected in one another (Alvesson & Skoldberg 2000; Cunliffe 2002). Using this reflective/reflexive empirical approach therefore, the focus shifted from handling of empirical material towards a consideration of the perceptual, cognitive, political and cultural circumstances that formed the backdrop – as well as impregnated – the interpretations made by the researcher (Alvesson & Skoldberg 2000; Alvesson 2003). A reflexive interpretive approach involved giving thought to how one thinks about thinking in assessing the relationship between knowledge and the ways whereby knowledge is produced, and between knowledge and the knower (Harley, Hardy & Alvesson 2004).

Interpretive research implies that there are no self-evident, simple or unambiguous rules or procedures that can be applied in a mechanistic way (Bourdieu & Wacquant 1992; Klein & Myers 1999; Alvesson & Skoldberg 2000). ‘Crucial ingredients are the researcher’s judgement, intuition, ability to ‘see and point something out’, as well as the consideration of a more or less explicit dialogue – with the research subject, with aspects of the researcher herself that are not entrenched behind a research position, and with the reader’ (Alvesson & Skoldberg 2000, p. 248). For this researcher this meant knowledge about the phenomena emerged over time through a reflexive process in which successive understandings built upon earlier reflections and interpretations.

The reflexive interpretive process supported the interpretive methodology in this research for at least two reasons. Firstly because the focus was on exploring how managers made sense of their context and shared accounts in order to make decisions and construct interorganisational relationships. Secondly, the approach enabled interorganisational relationship management to be better understood by getting ‘inside’ the social and cultural context of the phenomena. This required the researcher to understand the phenomena from the point of view of the participants - the social actors – and to challenge and reflect on the sense-making process.
Throughout the researcher attempted to ‘experience’ the phenomena and use a reflexive process to distil new understandings. This has continued to be an ongoing process of learning.

### 3.2.2.2 Qualitative Methods

Reflexive interpretive methodology is suited to use of qualitative methods. In this research the qualitative methods used were participant observation, interviews, recall and reflection about personal experiences and the writing of personal accounts, or narratives. These research methods are elaborated in Section 3.4.3. Each of the qualitative methods contributed to the construction of six narratives that are presented in Chapter 4. These constructed narratives emerged from an iterative writing process during the researcher’s reflective/reflexive interpretations.

This reflection and writing about the researcher’s lived experiences extended over the five year period 1998 to 2002. Pellatt (2003) and Richardson (2000) referred to such extended periods of study, as auto-ethnography. Richardson (2000, p. 931) defined auto-ethnographies as ‘highly personalised, revealing texts in which authors tell stories about their own lived experiences, relating the personal to the cultural’. Martin (2002, p. 110) used the term ‘life history’ to describe similar approaches in which there was the ‘potential to reveal the most intimate thoughts and actions of a person including their moral struggles, achievements and disappointments in a social context’. In taking the auto-ethnographic approach the researcher has responded to Alvesson’s (2003) challenge that researchers study the ‘lived realities’ of their own organisational workplaces. While such auto-ethnography can be risky because it has the potential to expose the researcher, it also contributes ‘thick’ (Geertz 1973) description of phenomena from the ‘inside’. The ‘inside’ context is a key attribute of interpretive research. This research context, or setting, is discussed in the following section.
3.2.3 The Research Context

Interpretivist research is a culturally driven approach that places significance on the setting of the research. In this research the context comprises six interorganisational relationships at the Hospital. The researcher held the position of Manager at the Hospital throughout the research period. Her responsibilities included oversight of the Hospital’s outsourced near-core clinical and peripheral non-clinical, support services. The interorganisational relationships were all in place before the researcher took up her position at the Hospital. The researcher was a member of Hospital’s executive and worked with other managers of the Hospital community. The research setting was not contrived and others were aware of her research. The researcher exercised her responsibilities as a senior executive with accountabilities to her Chief Executive and her Board.

While the researcher as Manager has made ongoing reference to the social and cultural context of her management activity, the situational context of the researcher also requires recognition. Authorship is associated with issues that stem from the juxtaposition of the researcher to the subject of the research (Van Maanen 1996; Jeffcutt 1993; Alvesson & Skolberg 2000; Cunliffe 2002; Bourdieu 2003). The role of the researcher and the issues raised by this are considered in the following section.

3.3 The Role of the Researcher

In auto-ethnography, knowledge construction is by a ‘knowing’ participant and is embedded in the actions and routines that the researcher presents in her narratives. The process of interpretation was an ongoing one in which reflective dialogue and reflexivity enabled the researcher to make sense of her experience of managing interorganisational relationships. Sometimes the researcher describes her experiences, in her role as Manager, in a ‘confessional style’ as referred by (Van Maanen 1990).

The researcher (as the Manager) was exposed and vulnerable in the narratives. At times she placed herself in ‘strange spaces’ wherein the various ‘selves’ have pondered over interpretations, what to include, ‘how far to go’. In preparing her narratives the researcher explored different ways to write and ultimately adopted a
third person stance with first person accounts by the Manager and other managers interwoven with the more descriptive and interpretive text.

This research is approached from the researcher’s perspective as a client Manager and as an ‘insider’ in the interorganisational relationships. The research, therefore, presents an insider (emic) perspective of the phenomena. The duality of the researcher’s roles has facilitated access to information and situations that might normally not have been available to an ‘external’ observer. The insider role has enabled the study to be conducted over an extended period of time that might have proved difficult for an external researcher. The dual role has also meant that at some times the researcher was an ‘outsider’ and at times, in her daily role as the Manager, an ‘insider’. In the ‘outsider’ role the researcher has attempted to take a dispassionate view to enable a more critical interpretation. Sometimes this was risky, particularly when the research critiqued her management behaviours and decisions. This is the essence of reflective study.

Nurse Managers, the Dietician, the Payroll and Human Resources Managers and the Manager of Finance (who were interviewed in this research) represented other client managers who were sometimes more ‘inside’ the interorganisational relationship management on a daily basis than the researcher in either of her roles. Close working relationships with these other managers enabled the researcher to present front-line perspectives of interorganisational relationship management activity. The interpretations produced in this research are from operational managers lower down in the organisation. They contribute the insider managers’ view and this goes beyond the normal top-down views often presented in organisation studies (Alvesson 2003). The narratives in this research are constituted of collective sense-making about experiences and interpretations developed in diverse settings within the Hospital.

Reporting from the inside can be risky and difficult. It can be confronting to explore something to which is very close. The next section examines some of the ethical issues associated with auto-ethnography.
3.3.1 Ethical Issues

The researcher was actively engaged in the object of her research. She was involved in the Hospital’s interorganisational relationship management while also an active observer for the purpose of her own research. This raises ethical issues as it is difficult to study something that one is heavily involved in. Auto-ethnography may increase the vulnerability of the researcher and others in an organisation. There is the chance that norms may be broken. Organisations have notions about loyalty and behaviour for people in different roles and positions in the organisation. Understanding how an organisation ‘really’ works requires ‘micro-anchoring’ (Alvesson 2003) and there is vulnerability in this. For the researcher this has meant the possibility of subjecting herself to criticism about disloyalty and questions about professional conduct. The researcher relies on knowing that she is honest in exposing her inner thoughts and recording the comments and observations of other knowing participants. Her duty has always been to the needs of her organisation balanced with those of others who have been served. In the ethical context such honesty in personal perceptions can be a significant managerial dilemma. In the organisation context such ethics are generally managed with governance mechanisms that protect individuals and other organisations. In the research context confidentiality and anonymity is assured.

For the researcher there may be some horizontal and vertical political dilemmas in involving other lower level managers. Horizontal political-ethical dilemmas may be associated with conflicts about power and cultural capital when social actors are in competitive relationships. In this research only one side of the relationship management perspective is presented – that of the client. Vertical political-ethical issues associated with the researcher’s executive role in the lived experience gives rise to the possibility that subordinate managers will bias their interpretations and conversations to suit the social context of a discussion with the Manager, knowing they need to maintain working relationships with her. The researcher has attempted to balance any opposing views of others with self critique and reflection. Regardless of these efforts, however, it likely that there have been times when the researcher has been ‘selective’ in what she has chosen to reflect upon and report. This is acknowledged.
Another issue stemming from the presentation of only the ‘client’ view is the chance that readers may form a view about the external provider organisations unreasonably derived from the researcher’s view. The ‘client’ view is presented as though it was the ‘mainstream’ view. In this regard the ‘difference’ that is represented by the provider’s (‘outsider’) view is omitted. There is, for example, a tendency to represent some providers’ services as being too expensive or not responsive to customer’s needs. Conversely, the Hospital is seen to have been caring of its staff and better at looking after its staff. Further, the question: ‘Why do we have to do their business for them?’ could be interpreted as querying the competence of the provider organisation without the opportunity for it to respond.

This polarising this does not mean that the outsider – the provider’s views - have not been considered. Their contribution is embedded in the development of the researcher/Manager’s tacit knowledge and in the explicit knowing and interactions that occur in the social interaction of the participants. Nonetheless, these issues are acknowledged. The researcher suggests that this is a further source for creative enrichment and may be the context for a further research agenda.

The researcher has taken the research as an opportunity for reflexive practice. To this extent her own management interpretations and behaviours may have been affected during the course of the research. The researcher was known to the Hospital and to the service providers to be undertaking the study. Some of the service providers took advantage of this to engage in learning discussions and were keen to reflect on the workings of the interorganisational relationships, their construction and their management. This has meant that the researcher and other participants have benefited from reflective learning practices. In the nature of reflective practice, reproduced knowledge could be implemented ‘along the way’. This characteristic is more typical of the interpretivist view that reality is forever being constructed and that researchers who engage in this way find themselves immersed in never ending, evolving phenomena.

It is also possible that other managers associated with the phenomenon may have ‘acted up’ for the researcher. However, the duration of the research and its reflexive
positioning may have absorbed some of this impact. The experiences and views of other participants in the social phenomenon were not always in accord with those of the researcher/Manager but these different interpretations are acknowledged by the researcher in the narratives. They have also been used as a stimulus for further reflection by the researcher/Manager.

The researcher recalls ‘events’, or ‘ah, ah’ moments (Klein & Myers 1999; Cunliffe 2002), when the interpretations of others about daily interactions were the stimulus or catalyst for much reflection. For example, the researcher recalled when she was told by an external provider: ‘You don’t trust me’. This was a defining event for the Manager and led to much reflection and much agonising about whether this could be true. Issues, such as this, are further developed in Chapter 4.

The researcher has taken care to respect these different subjective meanings and so the views of other participant managers are included in the researcher/Manager’s narratives and in the researcher’s reflexive interpretation. Thus, the researcher has attempted to include as faithfully as possible the lived experiences of other manager participants.

For the researcher being personally involved in the context of the study also means that one may be less able to liberate oneself from some taken for granted ideas or ways of viewing things. Having commenced the study the researcher experienced a heightened responsibility to ‘see the project through’. There were always concerns about whether others would be happy with the research outcome and if the narratives produced would do justice to the expectations of others. Ultimately the text produced is fictional because it does not mirror something that is out there. It is authorial. As Alvesson (2003, p. 173) says, ‘it tells a story, it adapts a particular style, the author makes all kinds of moves in order to create certain effects, e.g. trust-worthiness, legitimacy, brilliance’.

The Chief Executive of the Hospital and other senior managers were each aware of the conduct of the study and have shown ongoing interest and support. The Swinburne University Ethics in Research Committee has accepted the study.
This section has identified some of the ethical issues associated with this research. The research has involved a lengthy engagement with the phenomenon at the Hospital. Guba & Lincoln (1989, p. 237) said that by being in the field for five years and with a substantial involvement, the researcher can ‘overcome the effects of misinformation, distortion, or presented ‘fronts’, to establish the rapport and build the trust necessary to uncover constructions and to facilitate immersing oneself in and understanding the context’s culture’.

3.4 The Process of Enquiry

Interpretivist research includes three main phases: entering the field, selection of the fieldwork context, and finally the methods and presentation of empirical materials. The research process is recursive and aspects of each phase may be repeated until the researcher feels a comfortable ‘closure’ is attained. This section describes the process of enquiry for this research.

3.4.1 Entering the Field

This research began after the researcher spent approximately twelve months in the field grappling with the complexities and challenges associated with her new role as manager of interorganisational relationships at the Hospital. It appeared to the researcher that management across organisations was difficult and in contrast to her traditional management roles. The duality of delivering on the Hospital’s budget control on non-clinical support services, improving service quality and sharing this responsibility with other external organisations that wanted to profit from their service delivery to the Hospital, was an added complication. The Manager struggled with how to make sense of this and at the same time develop these relationships in the way her Chief Executive wanted which was ‘partnership’ rather than contractor management.

The research problem emerged after the researcher’s reflections repeatedly led her to wonder why it was so difficult to manage these interorganisational relationships:

Just what is this difficulty – is it me? Is it the job? Is it the sharing of responsibility with another organisation? What is it that makes it so
hard? Others with whom I work also tell accounts of the same difficulties. Why is it that I seem unable to make sense of all this?

The idea of a reflective interpretive study that would give the researcher this legitimate thinking space within her organisation was developed. The researcher approached her Chief Executive with the proposition that she undertake this research as a way to engage in such reflexive practice and at the same time use her reflective practice to benefit the organisation. With his support the research commenced. A project plan and timeline was prepared but revised regularly in response to contextual changes and demands of the research.

Field work refers to ‘an interactive-reactive cycle of inquiry’ (Zaharlick & Green 1991, p. 219). As the fieldwork proceeds and fresh discoveries are made, the researcher reflects and redefines problems and research methods. The method of enquiry, once in the field, namely identification of the interorganisational relationships context, the reflexive interpretive analysis of the managers sense-making about managing interorganisational relationships, and the presentation of the Manager’s constructed narratives about her experience of the phenomena, are discussed in the following sections.

3.4.2 Selection of Interorganisational Relationships

Six interorganisational relationships were purposefully selected for in-depth exploration of daily interorganisational relationship management activity. The interorganisational relationships had clearly defined parameters which included:

- They were all support services to core hospital activity (nursing and patient care);
- They were all identified by the Hospital as ‘outsourced services’ and they all involved an external service provider;
- They all operated during the study period, 1998 –2002;
- The researcher had a management responsibility for each of the interorganisational relationships, and
They were all accessible for longitudinal study in the participant observer mode.

Table 3-1 identifies the six interorganisational relationships. The inclusion of three interorganisational relationships in each category is co-incidental and reflects the parameters described above. Each interorganisational relationship delivered services for Hospital employees, clinicians and patients. The Human Resources interorganisational relationship was least likely to deliver services to Hospital patients.

**Table 3-1 Six Hospital Interorganisational Relationships**

<table>
<thead>
<tr>
<th>Service</th>
<th>Type</th>
<th>Level of competency</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Imaging</td>
<td>Clinical support</td>
<td>Near-core</td>
<td>Full</td>
</tr>
<tr>
<td>Pathology</td>
<td>Clinical support</td>
<td>Near-core</td>
<td>Full</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Clinical support</td>
<td>Near-core</td>
<td>Full</td>
</tr>
<tr>
<td>Food Services</td>
<td>Non-clinical support</td>
<td>Peripheral</td>
<td>Partial</td>
</tr>
<tr>
<td>Environmental Services</td>
<td>Non-clinical support</td>
<td>Peripheral</td>
<td>Partial</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Non-clinical support</td>
<td>Peripheral</td>
<td>Partial</td>
</tr>
</tbody>
</table>

Source: Developed for this research

The terms near-core clinical support and peripheral non-clinical support were defined in Chapter 1. ‘Accountability’ refers to the extent to which the Hospital outsourced a higher or lower proportion of the service delivery. It is a subjective description only and used by the researcher to describe her understanding of the ‘completeness’ with which a service was purchased from an external provider. For illustration, the Hospital retained no internal competency to deliver diagnostic imaging services and all such services were delivered for the Hospital’s patients by another provider. In contrast, The Human Resources function was deployed to Hospital line managers but the Hospital purchased human resources advice and support for line managers, from an external provider. Hence, the Hospital retained a significant level of internal human resources competency.
The next section outlines the research methods that were used to construct the researcher/Manager’s narratives about the management of six interorganisational relationships.

3.4.3 Data Collection Methods

The researcher’s active participation and observations provided her with a detailed ‘window’ on interorganisational phenomena as they emerged. Participant observation, six interviews and readings of various documents that describe the formal interactions between interorganisational relationship members, and the Hospital, provided the main methods to support the reflexive interpretive approach. These methods are discussed in the following sections.

3.4.3.1 Participant Observation

Guba and Lincoln (1981) proposed a topology of subject/observer relationships that was built around three factors:

- Whether the observer is a participant or non-participant.
- Whether or not the subject is aware of the observation taking place.
- Whether the situation is natural or contrived.

Participant observation is a social method to collect qualitative ‘data’ and depends primarily on the observation of individuals and collections of individuals in context. Language and symbols are integrated through the process of interpreting and documenting the observed elements and patterns of social interaction. During participant observation the researcher not only ‘lives the experience’ of interorganisational relationship construction, but also reflects on individual and group behaviour and tries to interpret these in the cultural, physical, social and emotional contexts of the phenomena.

The researcher brings her own knowledge and interpretation to the construction of new knowledge about the phenomena. Her sense-making about events has produced
unique accounts. Over the research period, the Hospital was receptive to the researcher’s interpretations, and as a consequence, new knowledge may have been embedded in later actions and further reflections by participants. The sharing of these interpretations over the period of this research enriched the reflective practice and contributed to the findings in the research. This is consistent with an interpretivist perspective, which rejects the notion of a ‘definitive account’ of social phenomena and accepts the inherent plurality of possible social meanings.

Various researchers (Woods 1986; McTaggart 1989; Yin 1994) have identified advantages in participant observation. The method permits empirical materials to be produced in instances where other sources and actions may be impossible. Observation can enable rich knowledge to be constructed. In this study the researcher is very much an insider. This places the interpretation of events within a particular cultural context. Observation can also be combined with other information sources and experiences that can contribute to the interpretive process.

The six narratives about interorganisational relationship management are constructed accounts of the researcher’s experience on the ‘inside’. They represent her interpretations, as a key actor, of the interorganisational relationship phenomena at the Hospital. Unlike the more passive observer’s use of documents, this researcher has contributed to the construction of these documents (diaries, memos and professional records) which record a contextual memory of events and add to the researcher’s subsequent interpretations. In this way the researcher/manager’s tacit and explicit knowledge became part of the researcher’s re-interpretations. The observations and the construction of empirical materials for this dissertation can all be considered to be part of the one process of interpretation and knowledge production.

Alvesson (2003) proposed that ‘observing participant’ was a better term than ‘participant observer’ because the researcher was an active participant, more or less on equal terms with other participants. Rather than a long-term visitor to the social setting this researcher ‘lived’ in the setting. The research was ‘not a major preoccupation, apart from the time when the empirical material [was] targeted for close scrutiny and writing’ (Alvesson 2003, p. 174). The experience of working in
the social setting was available to the researcher to use, along with knowledge and access to other social actors and materials for research purposes.

3.4.3.2 Interviews

During the period of writing and reflecting the researcher also held six interview-style conversations with other client managers who were closely involved in the interorganisational relationships. This section describes how the interviews were organised and conducted.

Interviews were conducted to gather the inter-subjective experiences and interpretations of six managers who participated with the researcher, as the Manager, in sense-making about managing the interorganisational relationships. The small sample was a purposive one, and was consistent with interpretive inquiry where the emphasis is on depth rather than breadth. The six people were selected because the researcher knew that they had specific experiences of managing in the interorganisational relationship context at the Hospital. The researcher used her inside knowledge to identify these interviewees. They, therefore, provided ‘an information-rich sample selected to illuminate the research focus’ (Green 2002, p. 11).

The following managers were selected for interview:

- The Manager of Finances had responsibility for the Hospital’s finances. In particular he was involved in the initial set up of the interorganisational relationships. He had a particular interest in the Pharmacy Services Supply Agreement because pharmacy was an escalating expenditure in the clinical budget and expenditure lines.

- The Senior Dietician was responsible for dietetics and patient nutrition in the Hospital. She liaised very closely with the Food Services provider and staff so that patient dietary needs and standards could be incorporated in the meal plans, menu design and food service delivery.
• The Payroll Manager was also an accountant and human resources practitioner. She supported the Manager in analysing wages and salaries expenditure, in negotiating with the unions on enterprise agreements and in managing workcover premiums. The particular construction of the food and environmental services provider contracts made the monitoring of this expenditure a responsibility of the Hospital. In addition the Manager had continuing responsibility for more than two hundred Hospital employees who were managed by the external provider.

• The Human Resources Adviser was an employee of the external service provider of Human Resources advice. This Adviser also supported other external service providers working within the Hospital. In particular, the Human Resources Adviser supported the Hospital’s food and environmental services employees who were managed by another external services provider. The Human Resources Provider also supported the Hospital in liaising and negotiating with the external food and environmental services provider, with the unions and sometimes directly with her own employees.

• Three Nurse Managers who had responsibility for patient care. They received the services delivered by the external providers and in the patient’s understanding they had responsibility for the services provided. On a daily basis these managers could assume responsibility for the ‘customisation’ of the services from the external providers. They received feedback from patients and doctors and they handled complaints.

The interviews were semi-structured, and approximately one hour in duration. They were conducted at the Hospital. The purpose of the interviews was to gather other Hospital managers’ understandings and perceptions of their involvement in managing their service responsibilities in the collaborative context of the interorganisational relationships. Managers talked about their experiences, their emotions and their relationships with the external providers.
The researcher decided not to interview patients because the focus of the research was on the activities and sense-making by the Hospital’s managers as they implemented the interorganisational relationships. Patients were the recipients of the services delivered through these relationships. Each year the Hospital surveyed its patients about their experiences with a range of clinical and non-clinical services, including those delivered through the interorganisational relationships which are explored in this research. The researcher/Manager had access to this information for her sense-making.

Preparation for the interviews involved two stages. First, contact was made with each interviewee to discuss the objectives of the interview. The interviews varied from thirty minutes to approximately one-hour and depended on how much the interviewee wanted to engage in conversation about the subject. All of the interviews were conducted at the Hospital in the researcher’s office. The conversations were audio-taped and transcribed. Secondly, the draft transcript of each interview was made available to the interviewee to be sure that they felt comfortable with the material produced from the conversations. The semi-structured interviews kept the central two research questions in mind:

Research Question 1: How are interorganisational relationships managed at the Hospital? and,

Research Question 2: How does management activity differ between interorganisational relationships at the Hospital?

The interview protocol was designed to be used in a semi-structured interview setting. (Refer to Appendix 1). It is acknowledged that this protocol allowed the researcher to guide and engage in the interviewee in a ‘bounded’ or focused discussion. Each interview was conducted in the workplace. The interviewee was informed about the research project and how the interview would be focused and framed (Scott & Usher 1999). The interviews took the form of a conversation within this focus. Within this social context (of the interview) the lived experience of these managers was hoped to be revealed. The researcher attempted to make the interviews informal and they took the form of a conversation between work colleagues (Burgess 1984; Silverman 1993).
This approach respected and enabled the various experiences and understandings of the participants to be expressed.

The interviews gave the researcher access to the ‘skilled performances of social actors’ (Scott & Usher 1999, p. 113) and the ‘knowledgeability of [them as] relevant agents’ (Giddens 1984, p. 329). The researcher explored interviewee remarks where it seemed possible to uncover more of the participant's perspective but otherwise respected how the respondent reflected on their experiences. The different impressions articulated by the interviewees added to the richness of the descriptions about interorganisational relationship management in the Hospital.

Each interview was audio-taped with the interviewee’s consent. A verbatim and complete transcript of each interview was made and these interview transcripts and made available to the interviewees. Notes, transcripts and micro-cassette audio recordings of the interviews, together with copies of relevant documents are held by the researcher.

From the researcher’s perspective these interviews were seen as a way to compare her own recall with other manager’s involved in the interorganisational relationships. They also enabled her to give expression and acknowledgement to the voices of others involved with her in the phenomenon. How these other managers were making sense of acting in this social construct helped with her sense-making.

Interviews can be viewed as problematic because a stance presented may challenge the idea of ‘the conscious, autonomous, holistic and clearly defined individual as the bearer of meaning and as an active and ‘acting’ subject around which the social world rotates’ (Alvesson 2002, p. 116). As well assumptions about the individual ‘as a coherent, unique and, in terms of motivation and cognition, more or less integrated universe – a dynamic centre for consciousness, emotions, evaluations and actions’ (Geertz 1983, p. 59) may be viewed as problematic.

The interviews/conversations represent ‘other voices’ – other people’s knowledge. These other voices contribute to that context of the researcher as she constructs her own social reality. Eisenhardt (1989), Scheurich (1997), Scott & Usher (1999),
Hollway & Jefferson (2000), Foutana & Frey (2000) and Alvesson (2003) are critical of the interview method in qualitative research highlighting at least three dimensions: the interviewer, the interviewee and the social situation. The following Table 3-2 summarises issues that they raised.
Table 3-2  Selected Issues Associated with the Interview as a Method

<table>
<thead>
<tr>
<th>Issue</th>
<th>Influence</th>
<th>Researcher’s comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are power relations between the researcher and the interviewee.</td>
<td>Interviewer and interviewee are members of different social practices and discourses. These positions may colour the way both approach the interview. Social markers convey messages about power and authority that can influence the behaviour of one party to the other. The spoken texts of the interviewees and the written text of the researcher are embedded within a set of social and political arrangements. The research text cannot exist without reference to the way it is constructed.</td>
<td>The researcher worked closely with these managers and assumed a ‘trusted’ colleague status. The interviewees referred to perceptions and interpretations that had been shared with the researcher as Manager. The researcher and the interviewee explored the meanings of comments made in the interview setting – beyond the protocol – as a way to break down any tendency to conform to a standard interview approach. The researcher engaged in a reflexive experience.</td>
</tr>
<tr>
<td>The researcher consciously selects who will be interviewed.</td>
<td>Some potentially valuable knowledge may be omitted. Bias, power and coercion may be involved.</td>
<td>There were few Hospital managers involved with the phenomena and who were part of the researcher/Manager’s sense-making. The researcher cannot recall a manager whose input she has not included in her reflexive interpretive process.</td>
</tr>
<tr>
<td>The researcher applies her own interpretation to the language of interviewees’ accounts and ‘reduces’ the comments.</td>
<td>Only selected information is included in the researcher’s narratives. There is a risk that material that does not reflect the researcher’s view is omitted.</td>
<td>As far as possible other voices have been included and acknowledged. The multiple views and individual ‘struggles’ of others in the sense-making process is identified as part of the researcher/Manager’s social context.</td>
</tr>
<tr>
<td>Issue</td>
<td>Influence</td>
<td>Researcher’s comment</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Interviews give ‘selected’ stories and act in certain ways. They can be ambiguous.</td>
<td>Interviewees may be politically aware and motivated actors.</td>
<td>Acknowledged. The researcher’s observations of interviewees suggest that while this probably existed, the views expressed at interview were no different than on those less formal occasions when conversing with the Manager. The richness of other stories conveys a message about the ambiguity and inconsistency of social ‘reality’ for actors in their settings. This appreciation enriches understandings about the fluid, uncertain, contradictory and complex nature of organisational life.</td>
</tr>
<tr>
<td>A strict focus on language of the interview gives ‘thin’ meaning.</td>
<td>Meaning and context should be factored in. The meanings produced by interviewees who are actors in the phenomena are significant beyond those only of the researcher. Metaphors offer interpretive lenses that relate to the ‘reality’ of interviewees and how they make sense of it.</td>
<td>The researcher is interested in the meanings of others in the phenomena since these stimulate her own sense-making and knowledge construction. The researcher observes connections between meanings and actions in the field. The research goal was to understand how managers made sense of their social context and how this translates into social interactions.</td>
</tr>
<tr>
<td>Interviews in themselves are empirical and ‘data’ gathered should not be used for outside this situation. Interviews are social situations and that which is said is context dependent.</td>
<td>Behaviour in interviews can be studied as much as any other empirical setting.</td>
<td>The researcher acknowledges the interviewee and the setting as far as possible. All settings are part of a bigger context. Different settings contribute new and alternate meanings. The narratives and interpretations in this research represent the researcher’s knowledge at the time of production. Subsequent reflection will always construct a further view. Knowledge production is an ongoing process.</td>
</tr>
<tr>
<td>Issue</td>
<td>Influence</td>
<td>Researcher’s comment</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>There may be problems interpreting utterances of interviewees. When people talk at interviews their language may be different to that used in other ‘real life’ settings.</td>
<td>Meaning is rarely self evident. At interviews interviewees may assume pre-understandings and shared frameworks which mean that stories are told in a particular way. Thus the performative aspect of talk may be lost at interview.</td>
<td>The closeness of the shared experiences between researcher/Manager and interviewees contributes to improve pre-understandings and shared contextual frameworks.</td>
</tr>
<tr>
<td>Interviewee accounts cannot be treated in definitive relationship to ideas, values, beliefs, motives or other cultural-level phenomenon.</td>
<td>The congruence of such accounts with other local cultural materials and manifested in actions may be difficult to investigate.</td>
<td>The researcher has viewed interviewee accounts at the Hospital. As cultural material that indicates values, ideas and situation-specific meanings.</td>
</tr>
<tr>
<td>Interviewee accounts do not necessarily reflect actual practice.</td>
<td>Practice includes cognitive, linguistic, behavioural, cultural, material and relational elements, but with some sense of their having a regularised/embedded/institutionalised character (routines).</td>
<td>The researcher views interviewee accounts as people’s ‘beliefs’ about the sense of their context and as influencing their actions. These beliefs (this knowledge) have some relationship to ‘facts’ about practices or management routines in the interorganisational relationship context.</td>
</tr>
</tbody>
</table>

The interviews were conducted during the period when the researcher was writing the narratives. They provided insights about what others thought and supported the researcher’s reflections. In this way the writing process and the interviews became part of the reflective dialogue that engaged the researcher. This process added richness and depth to the researcher’s interpretations expressed through her narratives.

In addition to active participant observation and interviews, the researcher had access to other sources and she used these during her reflective interpretation. In some instances these additional materials were produced by the researcher and they represent records of her sense-making over the research period. These other sources are outlined in the following section.

3.4.3.3 Additional Materials

During the preparation of the narratives the researcher had access to other empirical materials that she had produced over the period of the research. These included:

1. Field notes: The researcher kept her own diaries, developed over five years as Manager of the interorganisational relationships. The researcher/Manager has freely recorded matters relating to decision-making, meetings, interactions and events, as these occurred. She also had records of some personal reflections written after specific ‘events’ during her experience. These personal accounts reveal her personal attempts to make sense of experiences that affected her emotionally.

2. Meeting notes agenda and minutes: The formal records of meetings with interorganisational relationship services providers and other Hospital stakeholders have been included.

3. Patient surveys: Over the period of the research a number of patient surveys were undertaken that included feedback from patients about the interorganisational relationships.
4. Formal correspondence: Correspondence between the researcher as practitioner and various interorganisational relationship representatives has been accessible for reference.

5. Service agreements and contracts: These documents represented the formal record of intent between the Hospital and the interorganisational relationship services providers. These documents identify intent, objectives and governance matters.

These materials were not complete for any one interorganisational relationship. There are reasons for this. First, social actors did not always record their knowing actions when they were in everyday settings and acting in their own social world. In addition, there was also some variability in the ‘collection’ of empirical material because there was less than rigid adherence to a standard design. Further, each interorganisational relationship was unique and expressed the nuances, structures and sense-making of social actors involved. The interpretation of these materials was allowed to influence the process of selecting subsequent matters for exploration, and the selection of social actors who were best placed to contribute to the interpretive process (Horsburgh 2003).

The following section describes how empirical materials were prepared for presentation in Chapter 4. It builds on discussion about the reflective/reflexive interpretive approach in Section 3.2.2. This process of interpretation completes the third phase of the process of enquiry.

3.5 The Process of Interpretation

Interpretivist research focuses on the complexity of the subjective knowledge construction. The context and the process interact on multiple levels to enable understanding to emerge and to be presented in the writing of text (Klein & Myers 1999; Alvesson & Skolberg 2000; Cunliffe 2002; Alvesson 2003). Consistent with the interpretivist tradition, therefore, the collection and preparation of the empirical materials in this research became part of the analysis.
The following principles guided this research but did not completely govern it:

1. The researcher ‘borrowed’ understanding from other sources – from within the field. This immersion in the field established a level of preliminary understanding (a tacit knowledge). The researcher developed her own way to reflect on her ongoing management practices and to ‘draw into’ her sense-making, new knowledge about how to manage collaboratively. The researcher also built understanding and knowledge with awareness that the empirical data were not theory-free (Alvesson & Skolberg 2000).

2. The subject matter has been set in its context. The particular context of each interorganisational relationship is described early in the presentation of the narratives (Chapter 4). Each narrative contributes to the overall understanding of the management of interorganisational relationships in the Hospital.

3. The narratives are written from the perspective of the researcher, as Manager, and are constructed from the interpretive reflections of her lived experience. They include her social interaction with other managers involved in her experience. These narratives describe the researcher/Manager’s sense-making about her social reality. They offer a ‘thick description’ (Geertz 1973) of the interorganisational relationship management experiences of the Manager and other participants.

4. The researcher has considered parts, or aspects, of the phenomenon – the experiences, observations, conversations and discourses – as they played out in the field. In reflecting and making sense of the parts, she has also considered relationships with other interorganisational relationships, with them collectively, and with other managers’ experiences. This continuous movement between parts and the whole is what other researchers have referred to as the ‘hermeneutic circle’ (Klein & Myers 1999; Alvesson & Skolberg 2000; Cunliffe 2002). This ‘thinking and rethinking’ process (acting reflexively within circumstances) of evaluating and contemplating by the researcher, and by the researcher as field practitioner, has built deep understandings about the phenomena. Reflecting on others’ interpretations
and the consequences of new contexts and structures has contributed to a reflexive dialogue in which the researcher has come to examine her own suppositions and assumptions together with how these impacted on her construction of reality. As Cunliffe (2002, p. 40) observed:

Self reflexivity is critical because it is the basis for questioning the way we relate to others. By focusing on our own, often unacknowledged, representations of realities and working from within our experience, the impetus for change can be far more powerful than that mediated by externally imposed frames.

Throughout this process individual narratives were written and re-written. Over time this writing process enhanced reflection with additional insights because, with each successive rewriting, it was possible to construct further and new understanding.

5. One of the features of interpretive approaches is the principle of interaction between the researcher and the subject (Klein & Myers 1999; Alvesson & Skolberg 2000; Cunliffe 2002). In this research there was a multi-layered interaction between the researcher and the researcher as subject. The events that were identified, or written about, were the result of a social dialogue by the researcher in her dual roles. There were times when the researcher ‘stepped aside’ to critique her thinking and actions as the Manager. This approach offered opportunity for reflexive interpretation.

The narratives also incorporate accounts from other managers involved with the researcher/manager. The researcher recognised that these significant ‘others’ were also sense-makers and they offered their own interpretive accounts during their interactions with the Manager. What the researcher observed when she stepped aside was reflective dialogue; what the researcher/manager did and saw in interaction with other managers in the field was more what Cunliffe (2002) observed to be ‘reflex interaction’.

6. The narratives are the subject of a more reflexive dialogue, in Chapter 5, in which the researcher/Manager engaged in deeper and more critical questioning of her ways of understanding, being and acting in her social world.
When the context under study is the researcher’s own workplace, it can be more difficult to identify lack of alignment (‘breakdown’) between what one is seeing and one’s own schema-guided understandings (Alvesson 2003). To overcome this, the researcher attempted to create breakdowns by ‘locating [her] framework (cultural understanding) away from the culture being studied so that significant material to “resolve” emerges’ (Alvesson 2003, p. 185). The researcher has attempted to critique her own self-evident understandings.

7. Closure or saturation was reached in the reflexive interpretation process when the researcher could no longer think beyond what knowledge she had already produced. At this stage the researcher considered what further research might be undertaken to investigate the phenomenon and to construct new knowledge.

The researcher has avoided the deep textual analysis often associated with hermeneutics and phenomenology. While sorting and categorising of ‘data’ is not encouraged in reflexive interpretive studies (Alvesson & Skolberg 2000) the researcher has, however, identified themes from the narratives. The following section describes how and why this was done.

3.5.1 Identifying Themes

The narratives emerged from a recursive writing process. During this process and one particular period of quiet reflection, the researcher was ‘struck’ by the differences in her management approach to the interorganisational relationships. She became aware of ‘sensory contexts’ embedded in her explicit management actions. The researcher attempted to make sense of this by first ‘setting aside’ the emotion. She attempted to ‘simplify’ her thoughts, and to write down a description of her activity. This gave her with a ‘simple’ interpretive framework. Time was set aside from writing to think about these activities.

The researcher prepared a list of activity descriptions (Appendix 1) that comprised all the management activities that she could recall using within the interorganisational relationships. Then she reflected on her ‘level of involvement’ in each of these
activities, contemplated what other participants had told her and what she had observed them doing. As she reflected questions such as the following came to mind: ‘What did ‘involvement’ mean?’ ‘Was it the amount of time she spent with the provider, or the ‘effort’ with which these activities seemed to require?’ Further: ‘What are these “outsourced services” that take up so much of her time?’ and ‘Why did I do that on that occasion, and then do something differently on this other occasion?’ Further, ‘Why did I feel like that?’ and ‘Could I have chosen to think and feel differently about that event?’

During this reflective process the researcher/Manager became aware that the outsourced services were more than functions on the organisational chart. To her they were much more than that. The notion of ‘relationship’ embodied much more. They were unlike other functional responsibilities that she had where she controlled resources, had authority to make decisions, and had accountability in full to her Chief Executive, and her employees. Her managerial approach and her sense-making were different across the interorganisational relationships. On one level she sensed interorganisational relationships as structures within a wider structure of the Hospital. On another level, she sensed them as outcomes of complex processes during which she had to ‘meld’ a synergistic response from pluralist views and opposing orientations held by ‘others’. Routines ‘from elsewhere’ were juxtaposed in the service relationship. There was a latent, underlying, tension that stimulated sense-making on multiple levels by participants in the interorganisational relationships. She perceived that there were multiple perceptions and interpretations, such as those of other managers and also those that might be the providers, and that these were not always the same as hers. Her view was influenced by her situation as a Hospital client and she was able to sense that this view could be different to that of the external service providers. These reflections were a first layer of interpretation – what did she do, how did interorganisational relationships emerge from activities between participants, and how different were the interactions between participants in the various interorganisational relationships? As a consequence of these reflections the researcher began to find material for reflexive interpretation.

In her everyday management of the interorganisational relationships, the researcher/Manager began to observe more acutely the activities, her reasons for
them, as well as emotions associated with them. Field notes were kept and reflections made on these activities. In this way the researcher became more observant and engaged in a ‘quiet’ inward dialogue with herself.

When the researcher/Manager began to appreciate the emotion, and then the intent and purpose, embedded within her management activities, her reflections began to expose deep richer meanings. These were indeed complex. Sometimes the emotion appeared to derive from her view of herself. On other occasions it was a view of herself in relation to others in the Hospital. The researcher also became aware of her management style, of tensions within her between stewardship and collaborative behaviours. She also acknowledged an inclination towards power and control. The researcher exposed her ‘self’ to reflection about how she interpreted her position, her role in the organisation and how this translated into her activity. Through this reflexive interpretation the researcher became aware of alternative ways of thinking and behaving that could enhance her management of interorganisational relationships.

Throughout this process of reflection and reflexive dialogue the researcher became aware that her sense-making processes were influenced by ‘filters’. These filters acted like a lens to influence how the Manager ‘read’ her context, and also how she responded with her management activity. The Manager became aware that sometimes these filters created an internal tension, such as between her activities to control and her activities to devolve. She also felt emotional tensions between wanting to trust others and her ability to trust others. This sense of trust was related to controlling behaviours, such as her insistence on authorising the actions of the Food Services site manager, meeting with that manager repeatedly through small projects, requesting that services be improved, in her talking to front-line staff about how things were going for them. The Manager sensed that when she was more willing to ‘leave it to others’, such as when the Human Resources provider consulted with union organisers on her behalf over bans on the plating line, she did so because she sensed she could rely on, or trust, the provider to accomplish her objectives.

The researcher began to understand that each interorganisational relationship was described by a unique context wherein the Manager, and others, ‘lived’ a constantly adaptive experience that was neither predictable nor prescriptive. The only ‘certainty’
was change. Having reached this point the researcher began to experience a sense of ‘closure’. The researcher developed a sense of understanding about the practice of interorganisational relationship management.

This section has described the interpretive analysis of the six interorganisational relationships. It has included the process of reflection and reflexive interpretation in which themes were identified to explicate the sense-making process of the Manager about her practice of her managing interorganisational relationships. The next section considers the idea of trustworthiness in relation to this research and its findings.

### 3.6 Addressing Matters of Trustworthiness

The positivist criteria of internal validity, external validity and reliability are not helpful for evaluation of this interpretivist research (Lincoln & Guba 1985; Guba & Lincoln 1995; Coffey 1999; Strauss & Corbin 1990; Morse 1999a; Morse 1999b; Travis 1999). These criteria may be redefined as credibility (rather than internal validity), dependability (rather than reliability) and transferability (rather than generalisability or external validity) (Travis 1999).

The interpretivist perspective provides for multiple realities formed in the mind of the research participants and the researcher. This research takes an insider perspective contributing to the presentation of a social and cultural context that is unique. This approach enables a perspective on interorganisational relationship management to emerge that might not be possible for outside researchers. The researcher has been conscious of subjectivity in the collection of information, data and knowledge. To overcome this she has worked within a mutually acceptable ethical framework throughout the research and she has engaged in reflexive interpretation to question her biases, blind spots and ways of thinking (Travis 1999; Alvesson 2003).

#### 3.6.1 Credibility

Credibility is the degree of correspondence between the realities of the research domain and participants, and how closely the researcher interprets their intentions and realities (Guba & Lincoln 1989). In this research the researcher has been involved in
observing and reflecting about the interorganisational relationship management over a long period of time. This has afforded her a ‘certain distance vis-à-vis the material’ (Alvesson & Skolberg 2000, p. 286) that is advantageous to the interpretation process.

In the process of persistent observation, reflecting, interpreting, writing and exploring experiences with others, the researcher has chosen what is ‘relevant’ and what would be included in constructing knowledge about the object of study (the phenomenon). The researcher is, thus, embedded in a social context and in relation to others. Others who have been participants in the research context have confirmed their statements and contributions during the research process. Historical data exist in the research setting and are accessible.

Dependability is where the stability of the data (or the data gathering and analysis process) can be ‘tracked and is traceable’ (Travis 1999, p. 1043). To enhance the dependability of the study the researcher has also:

- Developed key descriptions of concepts used in the interpretive analysis of narratives, observations and interviews;
- Used multiple methods including participant observations, interviews, the review of documentation and archival records, all of which are acknowledged;
- Collected and stored ‘data’ so that an audit trail is possible if needed (after clearance on confidentiality issues), and
- Ensured that other participants in the interorganisational relationships reviewed their interview transcripts. Any inconsistencies or ambiguities were identified and clarified, thus, enhancing the overall quality of this research.

In the interpretivist methodology the empirical materials have been produced as the researcher’s understandings emerged through a reflexive interpretation. The auto-ethnographic style contributes to rich description of the interorganisational relationship management phenomenon. The researcher has acknowledged that the
constructed narratives represent her interpretations. Her authorship was about increasing opportunities for the reader to construct different readings:

The reader becomes significant, not as a consumer of correct results – the right intended meaning from the text and its author[ity] – but in a more active and less predictable position, in which interesting readings may be divorced from the possible intentions of the author.

The key concepts and catchwords here include multiple voices, pluralism, multiple reality and ambiguity. The good research text should avoid closure, following a monolithic logic. Instead, inconsistencies, fragmentation, irony, self-reflection and pluralism must pervade the work – writing of the final text as well as the thinking and note-taking that preceded it (Alvesson & Skolberg 2000, p. 171).

The research findings are unique to the Hospital context. The results may be compared with other findings from similar studies. It is not the intent to find a universal reality or establish the ‘truth’ about interorganisational relationship management. The participant interpretations of the phenomenon represent the lived experiences of these people within the interorganisational relationships at the Hospital. The narratives embody the political, social and linguistic contexts of the individuals.

It was not the intent of the research to produce knowledge for generalising to the wider population of interorganisational relationship management. This is the nature of interpretivist research. The researcher has produced a personal account of her experiences that is rich with embedded meaning and interpretation. Her interpretations may be vulnerable to others’ different interpretations. It is, however, her contribution to the field of understanding about managing interorganisational relationships. As an auto-ethnography it contributes a very personal account to research about organisation and offers opportunity for further reflexive dialogue in the community of practising managers.

The author has been in a privileged position to have access to relationship information and decision making, discussions, files and records of conversations and reports. Some of this information, particularly where sources have been acknowledged, must be considered confidential until cleared with the person or organisation concerned.
This section has examined briefly addressed issues relating to the evaluation of this interpretivist research and distinguished the approach from the traditional positivist evaluative one.

3.7 Chapter Summary

This Chapter 3 has outlined the approach to this research about sense-making in interorganisational relationship management. The interpretivist paradigm and the reflexive interpretive methodology were justified and the means by which the empirical materials have been constructed has been discussed. Issues relating to trustworthiness in the research have been considered. Chapter 4 presents the findings from the reflective interpretation in six constructed narratives. These narratives represent ‘data’, or the empirical materials, of the research.
4 FINDINGS: CONSTRUCTED NARRATIVES

4.1 Introduction

Interorganisational relationships emerge as managers make sense of working collaboratively. In this process managers draw on existing management experiences and adapt them. When the experience of managing interorganisational relationships is reflected upon and discussed with participants, the complexity of this sense-making process emerges. This chapter presents the empirical materials in the form of six constructed narratives. These narratives are like stories written by the researcher, and they describe how the Manager made sense of her management of interorganisational relationships at the Hospital.

4.2 The Context of the Narratives

Not-for-profit organisations like the Hospital have traditionally been associated with social or community goals. The Hospital has a Christian heritage and its not-for-profit status afforded it opportunities to develop services and technologies to compete for health care funding, capital and capabilities. Without the need to generate ‘profits’ for shareholders it has been able to develop and expand its range of services through reinvestment of profits into infrastructure development.

In recent times the Hospital, has begun to demonstrate behaviours more like those of a for-profit organisation. In 1992 the Hospital made a strategic decision to outsource some of its non-clinical support services and in so doing extend its network partners. At this time it had arrangements in place with three clinical support services organisations - pharmacy, diagnostic imaging and pathology. The Hospital coveted its reputation for excellence, as a leader and technologically advanced health care provider. Its employees also developed a strong identity and association with the Hospital’s reputation. The culture was always supportive and caring.

The 1992 decision to outsource non-clinical support services represents what Fox-Wolfgramm et al. (1998) call second order change. It was the Hospital’s response to increasingly tight health sector funding and contracting arrangements. The outsourcing decision not only impacted directly on employees associated with the
specific support services, but also numerous stakeholders, including patients and doctors. Further, it sent a message through the Hospital that core business areas were to be seen as profit centres and competitive.

In the late 1990s the Hospital purchased a smaller adjacent hospital. After the acquisition the outsourcing of services was extended to the new hospital campus. In 1999 and again in 2000 the Hospital was among the final two bidders for purchase of two more hospitals but missed out to more competitive bidders. In 2001 it was successful in tendering for the partnership development and operation of a new private hospital in an outer suburban region. Simultaneously in 2001 the Hospital entered into further partnering arrangements with more than thirty-five city clinical consultants who have made direct capital investments in new Hospital infrastructure. As a consequence a significant building project was commenced to expand clinical services delivered under the Hospital’s brand. Relationships are thus integral to the Hospital’s business strategy.

As noted earlier, six interorganisational relationships at the Hospital were selected and these have been discussed in Chapter 3. The six interorganisational relationships are summarised in Table 4-1.

### Table 4-1  Interorganisational Relationships at the Hospital

<table>
<thead>
<tr>
<th>Service</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Imaging Services</td>
<td>Near-core clinical support</td>
</tr>
<tr>
<td>Pathology Services</td>
<td>Near-core clinical support</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Near-core clinical support</td>
</tr>
<tr>
<td>Food Services</td>
<td>Peripheral non-clinical support</td>
</tr>
<tr>
<td>Environmental Services</td>
<td>Peripheral non-clinical support</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Peripheral non-clinical support</td>
</tr>
</tbody>
</table>

*Source: Developed for this research*

When the researcher/Manager commenced at the Hospital in 1998 the outsourced services were in operation. It was one of her responsibilities to ‘look after the outsourced services’. Each of the near-core clinical support service providers had
leased space in the Hospital. They each engaged their own staff, invested in all the necessary equipment, systems and infrastructure and delivered their services to the Hospital inpatients. Two of the providers billed patients directly (Diagnostic Imaging Services and Pathology Services) while the third provider (Pharmacy) billed the Hospital as well as the patient (pre-admission and discharge drugs). The peripheral non-clinical support service providers were also contracted by the Hospital. They utilised Hospital space and two of them managed Hospital employees. These employees appeared on Hospital organisational charts as ‘outsourced services’. The researcher observed that these employees had “somehow lost their identity”. They were still paid by the Hospital but through the contracted service providers.

The next section introduces the six constructed narratives. For ethical and confidentiality reasons, generic terms have been used to describe the external service providers. The researcher is referred to as the Manager. It remains important to retain confidentiality even though the Hospital may be identifiable and it may, therefore, also be possible to identify the service providers. For this reason there is a continuing expectation that the reader will respect the confidentiality of the empirical material.

4.3 Presentation of the Constructed Narratives

Each narrative is constructed from the researcher’s reflections on how she managed the Hospital’s interorganisational relationships. These narratives are presented in response to the Research Question One: How are interorganisational relationships managed at the Hospital?

Narratives are like stories; they give meaning to the events, actions and objects in our lives (Pentland 1999; Weick 1995). The six narratives in this research are the constructed forms through which the researcher has formed meaning and understanding about her lived experience as the Manager. Each narrative begins with a background description of the relationship between the Hospital and the external provider. Key features about the interorganisational relationship are set out in table form. This is followed by the (re)constructions of episodes and events that occurred during the researcher’s management of the relationships. The recalled episodes are
‘spun together’ and appear as though they make a continuous story (Flood 2002). The recalled experiences highlight the unique, complex and varied nature of collaborative relationship management.

The personal accounts are described in first person by the researcher in her position as the Manager. Use of the first person requires self acceptance which is integral to the reflexive interpretive approach adopted in the research and does not suggest that the research, or conclusions, demonstrate a lack of rigour (Webb, 1992, 1996). The narratives are presented in Sections 4.4 to 4.9.
4.4 Narrative One: Diagnostic Imaging Services

4.4.1 Background

In 1998 the Hospital’s imaging services provider was well established. The service provider was formed by a group of radiologists in the early eighties and had expanded as the Hospital grew. In 2000 the service provider was taken over by a much bigger health services organisation. This organisation was a major for profit corporate and this acquisition contributed to its expansion and vertical integration strategy. The location of the diagnostic imaging business in the Hospital site was attractive for a number of reasons. As the Hospital was a significant player in the private hospital business, and a competitor with its own hospital network, this acquisition, and particularly the Hospital services contract, was a significant coup. The purchase of the diagnostic imaging service placed the competitor physically and strategically within the operations of another key health care competitor. The new owner continued the delivery of diagnostic imaging services at the Hospital under a reassignment of the existing lease and a new Service Agreement.

The diagnostic imaging services provider engaged its own employees and was responsible to ensure that it met all professional and regulatory requirements including accreditation. The new provider had access to more resources to support infrastructure investment. This came to benefit the Hospital because the additional expertise and knowledge was made available to the Hospital doctors and their patients. Interfaces between the provider’s radiologists and radiographers, and the Hospital clinicians, surgeons, and nursing staff contributed to knowledge flows about developments in diagnostic imaging procedures.

The provider delivered outpatient services to patients referred to it by general practitioners and other consultants. The majority of the provider’s patients were Hospital inpatients. Services were available to the Hospital five days a week, with emergency and after-hours arrangements in place to support the Emergency Departments and the operating theatres.
The following table summarises the main features of this interorganisational relationship.

**Table 4-2  Features: Diagnostic Imaging Services Interorganisational Relationship**

<table>
<thead>
<tr>
<th>Service:</th>
<th>Diagnostic imaging services, for example, CAT, PET, ultra-sound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance mechanisms:</td>
<td>Monthly Clinical Services Partnership meeting, Lease and Service Agreement</td>
</tr>
<tr>
<td>Start Date:</td>
<td>In place 1998</td>
</tr>
<tr>
<td>Renewals:</td>
<td>1. Change of ownership during study period from ownership by small group of radiologists to large corporate</td>
</tr>
<tr>
<td></td>
<td>2. According to Schedule of lease reviews</td>
</tr>
<tr>
<td>End Date:</td>
<td>Ongoing to end of lease</td>
</tr>
<tr>
<td>Clinical/Non-clinical:</td>
<td>Near-core clinical support</td>
</tr>
<tr>
<td>Financials:</td>
<td>1. Lease payments to the Hospital</td>
</tr>
<tr>
<td></td>
<td>2. Patients billed direct</td>
</tr>
<tr>
<td>Key Clients:</td>
<td>Doctors and patients</td>
</tr>
<tr>
<td>Key Managers:</td>
<td>The Manager, Nurse Managers</td>
</tr>
<tr>
<td>Structure:</td>
<td>1. Totally outsourced; independent provider</td>
</tr>
<tr>
<td></td>
<td>2. No Hospital capability</td>
</tr>
</tbody>
</table>

*Source: Developed for this research*

Over the study period the provider invested capital in state of the art diagnostic imaging equipment. Innovation and advanced technologies enabled the Hospital to attract experienced clinicians who in turn admitted their patients to the Hospital. During the research period the Hospital’s occupancy grew so that both organisations benefited financially and in reputation.

### 4.4.2 Developing the Service Agreement

When the Manager commenced at the Hospital in 1998, there was no Service Agreement with the imaging services provider. The Hospital’s Quality Co-ordinator had commenced discussions with the provider about the Hospital’s desire for a
Service Agreement, but the discussions had not progressed far beyond a statement of intent. Until this time the relationship was solely governed by a lease that provided for up to thirty years of occupancy at the Hospital. The services were not defined and the performance standards and outcomes had not been identified beyond broad terms in the lease. The Manager observed that:

The leases were pretty standard documents. There was only one reference to the services to be provided and that was in the clause?“Services – refer to clause XXX” and Clause XXX referred to clause XXX. This was not very helpful. There was no articulation of the service relationship that would enable any monitoring or definition of how the service provision and relationship might be managed. It was the same for each of the three clinical support services.

The Manager recalled thinking that this absence of a service agreement “did not appear to be of great concern to the Hospital’s executive up to this time”. It was the Quality Co-ordinator who had raised this as an issue with each of the interorganisational relationships. She was informed about developments in the Hospital’s quality accreditation standards and had commenced a process to change the situation. ‘My sense was that she struggled in her efforts. She received little support from above and the provider’s appeared not to care. I think they were happy with the traditional informal approach. The Quality Co-ordinator had little experience in contract management. It became part of what I had to do in my role to manage outsourced services’, the Manager recalled.

Discussions with the provider about the service agreement were slow. Consultations were held, involving nursing staff, to try to agree to some service standards. This resulted in identifying indicators of timeliness or waiting times for service, patient satisfaction and doctor satisfaction, and levels of nursing support to patients. During the early discussions Nurse Managers expressed frustration about the difficulties they experienced when they tried to persuade the provider to make changes. This was probably because the lease bound the provider to nothing more explicit than providing ‘the services’. The Manager raised this concern on several occasions with the Chief Executive and the Manager of Finance:
It was acknowledged that insufficient consideration had been given to the service side of the relationships when the leases were originally prepared. I put my view that it would be difficult to change this now and we would have to rely on a constructive relationship to encourage the provider to change. The governance mechanism was a lease and nothing more. The providers were very secure and the Hospital was ‘captured’.

A service agreement was not accomplished before the new provider took over. The Manager and the Chief Executive were more concerned about the new provider because they were also a hospital services provider. ‘Suddenly having some mechanism to ‘protect’ the Hospital became urgent. This extended to restricting the new provider’s use of signage in our hospital’, recalled the Manager.

The Manager found that the new provider was more ‘sophisticated’ than the previous owner of the diagnostic imaging services and found them prepared to negotiate a service agreement with the Hospital:

They were very co-operative about a Service Agreement. In fact they took the initiative and had one drafted by their own legal advisers. We made more progress with them. Their corporate machine was good at this sort of thing and I must say it was good working with them on this. There was a sense of mutual purpose and appreciation of the task. It has to be said however, that our Chief Executive made it clear that the transfer of leases from the first provider would be contingent on the signing of a Service Agreement first. They had an incentive!

The negotiation of the Service Agreement occurred over six to eight months and involved meetings with representatives from the corporate office and lawyers. The Chief Executive and the Manager undertook the final negotiations with the provider.

While the relationship with the imaging providers had never been an “exclusive” one, opportunities for a competitor to provide an alternative in-patient service were still limited due to the need to be on site. Exclusivity became an issue when it was raised in discussion during the service agreement development. The Manager recalled:

The Service Agreement was negotiated through the period of change. The Hospital was edgy about the new provider. The Hospital’s legal advisers supported a clause in the Agreement to make it clear that the provider did not have exclusive rights to provide the imaging service.
It was also necessary for the Hospital to protect the possibility that some of its private consultants might install diagnostic equipment in their own rooms that we were selling them in the new strata titled Centre. The Chief Executive also wanted to retain freedom in this regard for the future. The provider came to accept the non-exclusivity clause and so it was included in the agreement that they signed.

4.4.3 Management of the Interorganisational Relationship

The Manager shared oversight of the provider relationship with the Chief Executive, the Clinical Services Manager who handled the property arrangements associated with the lease and Nurse Managers on the wards. The Manager kept the Chief Executive informed about any issues that were escalated from the wards, but otherwise remained the executive point of contact for issues as they arose. Matters relating to contract variation were discussed between the Manager and the Chief Executive. The Manager was aware that relationships were also maintained at the Executive level. The provider’s radiologists were accredited to practice at the Hospital and had representation on the Hospital’s peak medical committee. Relationships between radiologists and clinical specialists were maintained at clinical and professional levels.

On a daily basis the Manager had little to do with the imaging services delivery. The service provider employed its own staff from administrative to nursing, radiographers and radiologists. The Manager had no responsibility for any of the provider’s employees. She retained some responsibility to ensure that these employees were aware of hospital safety and emergency procedures and arranged for the providers staff to integrate with Hospital staff for emergency exercises. The provider was also included in hospital emergency situation exercises.

Nurse Managers had the most daily contact with the service provider. Clinician requests for diagnostic services and service quality issues created management interfaces with the provider. Appointment times/scheduling, transport and patient preparation, nursing assistance, report and film tracking, as well as patient comment and complaints, were the most frequent interface situations.
The Manager became involved if there was a complaint or a service problem raised by a ward staff member, occasionally a doctor, and Manager would call a meeting of the relevant stakeholders to work through the issues. In the situation of a patient the Manager, or a Nurse Manager, would make contact with the patient to try to resolve the problem. Further, the provider would also be contacted and asked to help investigate the issue. On other occasions the patient would contact the service provider directly. These tend to be the patients who understood that the imaging services were outsourced.

Sometimes clinical consultants made direct contact with the radiologist over a particular issue. This was achieved mainly through telephone contact from the ward or the consulting rooms. Clinicians expected film/images and reports to be available on the wards with the patient record. Sometimes the performance of the provider was the source of complaints (for example, missing film and late reports) directed at the nursing staff. Nursing staff subsequently had to follow up for the clinicians and hence took up some of the service shortfall by searching, calling, chasing up and explaining missing film, slow or missing reports.

At the Chief Executive level relationship management was strategic and involved the provider in negotiations with the Chief Executive for additional space and new technologies. The provider maintained a program of technology upgrade and replacement that benefited the Hospital’s patients and doctors. The better and more innovative the technology, the better the Hospital was able to appeal to clinical consultants, surgeons and patients. This created a positive outcome for the relationship: clinicians responded positively and admitted patients, the Hospital built its reputation and made money from inpatient stays, clinicians met their patients’ health care requirements and made money and the provider made money while building and expanding its business. There was little involvement by the Manager or Nurse Managers regarding new technology initiatives.

Each month the Manager chaired a Clinical Services Partnership meeting. This was a forum for both parties to discuss issues. The Manager recalled:
When I came to the Hospital I was told that one of my responsibilities was to look after ‘outsourced services’. This was a relatively new thing for me. Not being a clinical person, the areas of radiology, pharmacy and pathology I was not knowledgeable about the services. The best I felt I could do was to facilitate problem solving, manage stakeholder expectations and try to ensure that the Hospital received the support services it wanted. There appeared to be little intervention of any formal nature so I really took the path of steady as you go. It was clear that the providers had long and very secure leases. They had invested significantly in the technologies they required to deliver their services. There was no residual operation in-house and so there were very few staff with the competencies necessary to deliver the services. The medical and nursing staff could question technical aspects of the service reporting. I certainly could not. Relationships with the providers seemed to be positive. I did find that some problems kept coming up that there was quiet resignation to the fact that there was no choice anyway.

Nurse Managers reported activities that related most directly to services and complaints. The levels of frustration reported stemmed from a sense that they lacked ‘control’. Nurse Managers looked after a continuum of care that was punctuated with shared service responsibility. Patients did not often attach responsibility for specific aspects of their care with other providers. This meant that all service problems became the Hospital’s issues. The Hospital managers engaged with the provider to address problems and investigate patients’ experiences. If a patient had a bad experience it became the Hospital’s reputation that was affected.

There was a long standing tension over nurse support in the diagnostic imaging services. The key question was: ‘Whose nurses should be providing the patient support?’ For the provider the provision of nurse support to patients receiving imaging services was a resources issue. The Manager observed to herself the matter seemed to highlight some different perspective. The provider’s position was that additional nurse support was a cost to the business. In contrast, Hospital nurses view it from the perspective of patient comfort:

Our means to monitor quality of services was via patient feedback and doctor satisfaction. There was no internal Hospital expertise to be able to assess the technical aspects of the imaging services. This situation did not however protect us from complaints about the imaging service because most patients viewed this as part of their Hospital care.
This issue was a continuing challenge. Inpatients had a tendency to see Hospital staff as being responsible for the imaging services:

Because of our co-location and our efforts to make the services seamless there was a tendency in the patients’ view for the Hospital to carry all the accountability for service quality and price. Ensuring alignment of standards and a vision for best practice between the parties was a major task for those working the relationship. On the whole it worked pretty well with the imaging service provider. It was high tech and we were equally proud of being at the forefront. Inpatients received priority and there were rarely problems of timely access.

4.4.4 Billing

The provider billed the Hospital’s inpatients directly. The Hospital had no responsibility for billing patients for their diagnostic imaging services. The imaging provider negotiated its own contracts with health funding bodies and the Hospital was not privy to the details of those contracts. The Manager recalled a patient complaint that involved a patient’s perception of the service fees at the Hospital. This patient compared the Hospital fees with those charged for the ‘same’ imaging service at a comparable private hospital and complained that the Hospital was expensive. The Manager reflected:

Our provider was quick to explain that they had investigated the complaint. While the patient had a perception of the comparative prices the provider maintained that the services were in fact different. The investigation resulted in discussion about the provider’s pricing and their contracts with funding bodies. There was an inference that Hospital patients were considered ‘able to pay’ and that billing did vary across sites. It was important for me to explain the risk we carried because patients viewed the Hospital as the service provider when in fact we had no control of prices. The result was a request that billing and price setting responsibilities be clearly explained to Hospital patients.

As the Hospital’s business grew and occupancies increased, the Manager and the Manager of Finance often observed how the imaging provider also benefited. The Manager enquired a number of times as to whether the rent paid to the Hospital by the provider reflected the market available to the provider. It seemed to her and other ward staff that for all the effort the Hospital undertook to maintain high occupancies,
there was no mechanism other than a fixed rent, to reap additional rewards. She observed:

> We had no control over prices set by the provider. They delivered the services and billed the patients direct. This was because they had their own contracts with health insurance bodies. We did not monitor imaging service volumes and had no knowledge of their contracts with health funding organisations. Our Property Manager always assured me that the rental paid by the provider was a fair market rent and that pricing reflected the captured service market available to it. The rent was subject to a fixed annual increase and regular market reviews.

### 4.4.5 Monitoring

As part of development of the service agreement it was proposed to develop metrics to measure the performance of the service provider. This process commenced in 1999. The Hospital established a working party with representatives from the provider and the Hospital to identify and agree service delivery standards. The discussions in this group came to focus on the waiting times and level of nurse support for Hospital patients receiving the imaging services. The Emergency Department staff had ongoing concerns about urgent requests for service.

The Hospital’s Patient Liaison Officer conducted annual patient satisfaction surveys. These surveys reported patient dissatisfaction with their treatment given to them by the radiographers. The Manager recalled:

> The data from the survey show that patients felt inadequately informed about the treatment they were receiving when in the radiology services area. Some had complained about the waiting times and this appeared to be supported by nurses’ comments. Nursing staff were worried about the time spent off the ward, especially as some patients required to be accompanied by a nurse for the period off the ward.

The survey results were reported annually to the Hospital Board Patient Care Council. They were also reported to the provider. Nurse Managers tried to convince them to share their concerns and to respond to patients’ feedback. Successive survey results supported conclusions about the provider’s lack of responsiveness to some of the survey recommendations. Treatment of anxious patients awaiting diagnostic imaging procedures was one area that continued to be reported as an issue in these surveys.
4.4.6 Summary: Perceptions of Interorganisational Relationship Functioning

The Hospital was very dependent on the quality and delivery of each of its clinical support services. There was little residual competency that would enabled it to deliver imaging services for itself. The provider and the Hospital had a relationship that was symbiotic. Both benefited from the co-location. Ready access to highly technical services was available to the Hospital from a provider who was willing and able to invest its capital in innovation that supported clinician’s patient care services. There were two occasions during the research period when the Hospital made additional space available to the provider.

The Manager and the Manager of Finance had a strong financial perspective on the functioning of this relationship. The Hospital always worked to achieve increased patient throughput by developing further clinician relationships, supporting and adopting new technologies and negotiating new funding contracts. This activity resulted in increased market share for the Hospital and its external service support providers, who by virtue of being in situ, also benefited from this increase in market. As a consequence of having divested itself of internal capability in imaging services, the Managers perceived that the Hospital could be ‘hostage’ to the imaging provider. These senior managers were indicating that they might structure the service contract differently if they had their chance again. This suggests that they viewed their world differently in 1998. They felt ‘trapped’. Whether they truly appreciated the benefits of co-location with the provider, as shown by other measures, was not revealed.

While the Hospital received no revenue from services, it did receive rental income for the space leased to the provider. On an annual basis, rental rates were adjusted and every three years a market review was made. The Clinical Services Manager assured the Manager that the rental rates charged did reflect the benefits to the provider of an in situ Hospital market for diagnostic imaging services.

Social relationships were important in the collaborative service delivery. Interviews with Nurse Managers highlighted the importance of relationships with the site manager, particularly when it came to getting things done:
I found XXXX so approachable. We’d catch up and have a coffee, and I would say, ‘for God’s sake … falling apart at the seams,’ and she would say, “Oh my God, is that how you feel?” And then it was resolved fairly quickly and efficiently.

The Manager also reflected on the ease she felt in negotiating with the new imaging provider. The professionalism and expertise of the new provider seemed to appeal to her. She felt ‘involved’ in the process of developing the service relationship with the new provider. This was in contrast to her feelings of isolation from decisions about technology developments. Both the Nurse Managers and the Manager expressed positive emotions when recalling social interactions. They experienced an enhanced sense of connectivity with the provider’s employees.

At the Nurse Manager level, the focus was operational. Operational activities related to ensuring that patients and clinicians received quality services from the provider in a timely and relevant way. Patients tended to perceive the Hospital as responsible for the quality of the provider’s services. This frustrated some of the Hospital managers. Complaints and patient incidents were managed by Nurse Managers and these events sometimes raised questions about ‘patient ownership’ such as ‘whose patients are they when they are in the imaging department?’ Nurse Managers were most clear about their responsibilities when patients were in their wards. There was less clarity and less agreement, with the provider about responsibility for patients when they were not on the ward but in the imaging department.

On a daily basis the Manager believed that the provider’s services worked well and required little of her time. Her management activity was largely contract governance and issue resolution.

The following narrative relates to the near-core clinical support relationship with the pathology services provider.
4.5 Narrative Two: Pathology Services

4.5.1 Background

In 1998 the pathology provider was well established in the Hospital. Pathology services were delivered from a small on-site day laboratory at the Hospital. The laboratory was leased from the Hospital for the provision of these services. After hours it was supported from a twenty-four hour off site laboratory. Toward the end of the study period the pathology provider was taken over by a larger corporate. Table 4-3 below summarises the main features of the Pathology Services interorganisational relationship.

Table 4-3 Features: Pathology Services Interorganisational Relationship

<table>
<thead>
<tr>
<th>Service: Pathology Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance mechanisms: Monthly Clinical Services Partnership meeting Lease; Service Agreement</td>
</tr>
<tr>
<td>Start Date: In place 1998</td>
</tr>
<tr>
<td>Renewals: 1.Transferred to new ownership 2000 2.According to Schedule of lease reviews</td>
</tr>
<tr>
<td>End Date: Ongoing to end of lease</td>
</tr>
<tr>
<td>Clinical/Non-clinical: Near core clinical support</td>
</tr>
<tr>
<td>Financials: 1. Lease payments to the Hospital 2. Patients billed direct</td>
</tr>
<tr>
<td>Key Clients: Doctors and patients</td>
</tr>
<tr>
<td>Key Managers: The Manager, Nurse Managers</td>
</tr>
<tr>
<td>Structure: 1. Totally outsourced; independent provider 2. No hospital capability</td>
</tr>
</tbody>
</table>

Source: Developed for this research

The provider operated from leased space within the Hospital. This enabled the provider to deliver its services in response to the diagnostic requests of the Hospital’s clinicians. In the earlier years when the Hospital was smaller and less complex this
did not seem to be an issue. However, as the Hospital grew and the acuity and volume of patients increased, demand for urgent and more complex pathology increased. The Hospital’s emergency department, intensive care and high dependency units required access to twenty four hour services. While on-call services were provided, senior clinicians agitated for an extension of the on-site laboratory to a twenty-four hour service. The provider resisted these Hospital calls. ‘There were long debates about the meaning of ‘urgent’ but there was no resolution to this issue within the study period,’ the Manager recalled.

The pathology services scope did not extend to co-ordination of the Hospital’s blood and blood products service. A Nurse Manager who was very concerned about quality assurance issues managed this. There were several attempts to have the provider take over this responsibility but it remained resistant. This issue also remained unresolved at the end of the study period. Some benchmarking had commenced with the public hospital system and showed signs of providing useful leverage for change.

The pathology provider employed its own staff and they worked in a laboratory on the Hospital site. They also employed a team of couriers who visited the wards on daily rounds to collect patient bloods for testing and reporting. Most tests were performed on site but more complex analyses were made from a central off site laboratory. Results were faxed and emailed back to the wards, sometimes at turnaround times that met with dissatisfaction from clinicians and Nurse Managers. This was a source of particular frustration in high acuity areas, such as cardiac ward, intensive care and emergency department.

4.5.2 Developing the Service Agreement

There was no specification for the pathology services. The Manager reflected on her early attempts to develop a service agreement:

I had a distinct impression that this was not something that the provider wanted to do. Their Customer Relations Manager was nominated as the contact person. She could not see the need for a service agreement and she resisted our attempts. She avoided responding to our proposals and would have been happy with an exchange of letters I think. I was not able to progress anything with her despite my efforts to explain the
benefits to us both. The Head Office people did not appear interested and did not rush to support the site manager when I tried to work at that level. The local representatives were quite co-operative so we made some progress there.

I co-ordinated some meetings with Nurse Managers included and we completed a set of services and standards. This was accepted at the ward level.

During the research period the existing business leases were transferred to a new owner. While the Chief Executive and the new provider supported development of a service agreement, this was still only in draft form by the end of the research period.

As it emerged there was little incentive to sign a formal service agreement because the transferred leases confirmed the obligation to deliver ‘the services’ from the leased space. This resistance contributed to a sense of powerlessness amongst the Nurse Managers who used expressions such as the service ‘just happens … where is the leadership?’ One of these Nurse Managers observed how difficult it was to get change. Her impression was that the relationship was based on ‘reacting to issues’. Other Nurse Managers also observed that the pathology services ‘just happened’. By this they expressed their sense that they were doing very little to manage the pathology to their patients. One Nurse Manager reported that her relationship was ‘issue related; on an as needs basis … There were lots of small issues which kept getting put on hold because no-one had the time to deal with them … there was no commitment to go forward.’

The Manager and Nurse Managers felt that they had little ‘relationship’ with their local pathology provider. It was not uncommon for the Manager to escalate an issue to the corporate office of the provider to leverage some attention to the issues. In the absence of hospital capability in the pathology services, it was difficult for the Hospital to engage with the provider’s site staff. The Hospital relied on the provider to introduce new and more advanced pathology tests to the Hospital, at its own service initiative, rather than delay and wait for the Hospital’s clinicians to agitate for such tests. Clinicians became aware of new technologies from within their profession. Some also became quickly aware of these new technologies because they admitted patients to other hospitals where new tests were available. Hospital
managers and particularly the Manager because she did not have a clinical background, found it difficult to assess the quality of the pathology services and to evaluate if the provider’s services were ‘state of the art’. It was not until the Hospital took the initiative to look outside to what other pathology providers were delivering that it able to request an improved scope of services.

4.5.3 Management of the Interorganisational Relationship

The Manager became involved when Nurse Managers complained about the quality of services. Complaints to the Manager occurred after sustained attempts by ward staff to address problems directly with the provider. Issues normally related to the timeliness of pathology reports. There were also accuracy issues and missing reports from time to time. Timely and relevant reports were critical to patient treatment. While complaints overall were addressed satisfactorily, nurses always bore the brunt of doctor dissatisfaction if results were delayed. The Manager recalled:

When the provider changed its central information system without warning we suffered through a couple of weeks of disrupted service. Pathology reports became consistently delayed, mixed up, lost … it was terrible. It turned out the head office rolled out a new information system that caught the operation at our site ill prepared. It was a good example of how not to manage change. We had doctors threatening to change provider. In fact some did for a while. I had Nurse Managers alarmed at wrong and mixed up reports. It was bad. The provider kept apologising but excusing things. The local provider employees seemed ill prepared to operate the new system.

We had meetings and the Chief Executive Officer came in to assure us things would get sorted out. They promised us that the new system would have functionality we would appreciate.

4.5.4 Billing

The provider billed patients direct for its services so that there was no financial accountability to the Hospital other than the lease payments. There were few reported issues with pathology billing.
4.5.5 Monitoring

Every month the Manager chaired a Clinical Services Partnership Meeting. The other near-core clinical support service providers also attended this meeting with representatives of the Nurse Managers. The purpose of the meeting was to monitor and discuss issues relating to the provider’s services. Once a year the Hospital conducted a patient satisfaction survey and it included questions about the pathology services. The survey results were fed back to the provider with a request to them to follow up with improvement activities as appropriate.

Performance standards were identified but monitored only informally and on an exception basis. The main issues were around the response and turnaround times for reporting. There were attempts to define service standards but these were not finalised in the research period.

4.5.6 Summary: Perceptions of Interorganisational Relationship Functioning

Nurse Managers were generally satisfied with the pathology services. However, there were times when they vented their frustrations about the timeliness of results reporting and the slow implementation of new tests and technology. Most of the concerns came from the critical care nurses and clinicians. Their frustrations emerged periodically because of different interpretations of what constituted an ‘urgent’ pathology test and report. There was a tendency by the provider to question the clinician’s categorisation of a test as urgent. The provider considered that an urgent test was associated with a life threatening situation. Such speedy response times required more resources. The Manager reflected:

I accepted that our critical care directors were using clinical risk assessment in their decision making about patient care and safety, but that this did not equate to the pathologists assessment. In time I came to appreciate that our critical care teams were taking a very conservative path - possibly building in some contingency. As clinicians they had ultimate responsibility for the decisions in such life threatening situations.

The provider seemed to have some ‘power to resist’ the Hospital’s claims that turnaround times for urgent tests were not acceptable to it.
This was like a ‘stand off’ and it went on for some time. I had the Intensive Care and Emergency Directors complaining to me. In the end, after lots of time, the issue seemed to dissolve after I arranged a meeting with all these stakeholders in the Board Room with the Chief Executives of both organisations. In the end some teamwork and reasonableness prevailed. But I couldn’t help but think that this was aided by having the Chief Executives in the room. Why does this have to happen this way I asked? Why could we not have worked it out ourselves? I found it frustrating to have to use these authoritative figures to resolve the issue.

There was also dissatisfaction from time to time about the range of services. Some of the Hospital’s clinicians worked in other hospitals and they were thus able to compare the services provided to them through the Hospital. There were occasions when the Emergency Department and Intensive Care Unit clinicians threatened to call another service provider so that they could get additional services. ‘I believe we struggled for some time because we did not have enough information ourselves about pathology services to be able to call the provider to better account. There was a judgement by some managers that the provider seemed disinterested in taking any initiative to be really innovative – not like the imaging provider or the pharmacy provider,’ recalled the Manager.

Compared to the Diagnostic Imaging Services provider, the Pathology Services provider had less interaction with the Manager. The manager of the pathology services was not as ‘visible’ in the Hospital as the managers of the other two near-core clinical support services. These other managers were regularly seen around the Hospital and in the staff dining room. They dropped in on Nurse Managers and the Manager, and as well they participated in some Hospital committees. The most visible employees of the Pathology Services provider were the couriers who visited the patients’ bedside to collect bloods.

In narrative three the Manager describes her reflections about the pharmacy provider. The narrative depicts a relationship that was probably more effectively integrated with the Hospital’s culture and operations. While this next relationship ‘felt’ more comfortable for Nurse Managers, and the Manager, it was troubled by some sensitive ‘events’ in particular that stimulated sense-making among managers.
4.6 Narrative Three: Pharmacy Services

4.6.1 Background

The Pharmacy service was provided by a family owned business operating on the Hospital site in leased space well before 1998. There was a retail pharmacy service for staff, visitors and patients as well as the passing shoppers and other retailers. Table 4-4 below summarises the main features of the Pharmacy Services contract.

Table 4-4 Features: Pharmacy Services Interorganisational Relationship

| Service: | Pharmacy Services: Drugs, medication reviews, education, retail pharmacy services |
| Governance mechanisms: | Monthly Clinical Services Partnership meeting, Lease, Supply Agreement, Service Agreement |
| Start Date: | In place 1998 |
| Renewals: | According to Schedule of lease reviews |
| End Date: | Ongoing to end of lease |
| Clinical/Non-clinical: | Clinical support |
| Financials: | 1. Lease payments to the Hospital |
| | 2. Monthly drug supply invoice |
| | 3. Monthly fee for clinical services |
| Key Clients: | Doctors, patients |
| Key Managers: | The Manager, Manager of finance, Nurse Managers |
| Structure: | 1. Totally outsourced; independent provider |
| | 2. Some hospital capability |

Source: Developed for this research

4.6.2 Developing the Service Agreement

In 2000 the Hospital commenced a process to review its Pharmacy Supply Agreement with the provider. This stemmed from growing concern about pharmacy costs on the wards and an audit by an external consultant that showed an escalation of these expenditures. The Hospital wanted to control this expenditure.
Pharmacy expenditures were an important component of the pricing structure of funding rates negotiated with health funding bodies. The ongoing squeeze by the funding bodies on hospital funds served to highlight these growing pharmacy costs. At the same time as this, clinicians were always interested to use the newest drugs and the pharmacy provider was happy to supply them. The Hospital did not have effective control over utilisation and pricing of the pharmaceuticals for which it had to pay.

Pharmacy supplies were dispensed by the Provider through ward impresses or clinicians’ prescriptions. Clinicians had relative autonomy and, on the whole, they could order what they wanted. It was not uncommon for a critically ill patient in the Intensive Care Unit to require post-operative drugs that exceeded amounts that the Hospital could recover through its contract arrangements with the health funding bodies. This situation added to the imperative for the Hospital to negotiate a fair pricing structure with the pharmacy provider.

Negotiations were slow. There was little expertise in-house to undertake these discussions albeit the Hospital's health funds contract manager was a pharmacist by training. He became involved in reviewing the Pharmacy Supply Agreement as it was finally drafted and he also supported the Manager of Finance in negotiations. Relationships between the Manager of Finance and the provider became quite strained over the period and the Pharmacy Supply Agreement was not completed in the research period.

In addition to supplying drugs the provider also offered educative programs for ward staff. Pharmacists undertook ward rounds to collect scripts and review drug charts. They were integral to medication reviews and reporting of medication errors. Pre-admission, and post-admission, drugs were prepared for patients and for such medications patients were billed directly.

In parallel with the Pharmacy Supply Agreement, another working party led by the Manager had developed a Service Agreement. The Agreement was designed to govern delivery of clinical pharmacy services on the wards. Such services included pharmacy rounds, medication reviews, and drug discharge education. A consultative
working party was established to review current practice at the time and to agree key
performance indicators that focussed on timelines of service, reporting of errors, and
patient satisfaction.

The Service Agreement was finished in advance of the Pharmacy Supply Agreement.
Completion of the latter was delayed because it became entangled in discussions over
the pricing of drugs, ward imprest drugs and goodwill associated with the business.
This issue of goodwill was tied into any future potential sale of the business and was
raised in discussions because the supply of drugs was tied into the lease. For many
years the only formal agreement between the parties was a lease that referred to
‘Services’ and these were essentially defined as supply of drugs that would be
delivered from the leased site.

4.6.3 Management of the Interorganisational Relationship

The involvement by the Chief Executive in the daily operations of the contracted
services was negligible. The Manager kept the Chief Executive informed about any
issues. The Manager was the executive point of contact for service delivery issues
and the Manager of Finance managed the Pharmacy Supply Agreement. The
Hospital’s Board received monthly financial reports that highlighted the costs of
pharmaceutical supplies.

On a daily basis the Manager had little to do with the pharmacy services. There were
brief corridor conversations with the provider’s pharmacists who were regularly seen
around the Hospital. The Manager assisted the Manager of Finance and the health
funds contracts manager when they commenced to renegotiate a new Pharmacy
Supply agreement in 2000. Acrimony arose when neither organisation found it
possible to compromise.

During the course of these discussions the elder Pharmacy owner retired and his son
assumed management of the business. The younger pharmacy manager was very
keen to finalise the negotiations and appeared to want to find a ‘break through’.
However, the young manager had to defer to his parents so that progress continued to
be slow. The Manager of Finance was continually frustrated and there was pressure
on him to finalise the Pharmacy Supply Agreement. Finalising the negotiations was protracted because the parties could not agree an acceptable pricing mechanism for the pharmaceuticals.

As with the other clinical support services, the Manager had no responsibility for any of the provider’s employees other than responsibility to ensure that they were aware of hospital safety and emergency procedures. Pharmacy employees were also included in emergency situation exercises.

Nurse Managers had the most daily contact with the service provider. Pharmacists completed daily ward rounds to review medication charts and collect scripts and deliver drugs. Nursing staff had access to these pharmacists for information on medication issues, educative processes and to give briefing on clinical requirements.

The Manager became involved if complaints or service problems emerged. Most often nurses managed these at the ward level with the provider. Sometimes a meeting of the relevant stakeholders would be held to work through the issues. The issue of timing of the pharmacy rounds for script delivery was a common problem. The Manager became involved in a number of these meetings. Not all of the wards had the same requirements. For example, surgical and medical wards had different needs. Urgent services were met within-hours, and there was an after-hours on-call service. The provider often claimed that the wards failed to fit in with the pharmacy rounds and so win-win situations were difficult to find. A shortage of pharmacists during the research period led the provider to reduce after hours services to on call. This became a serious concern for nursing because of the twenty-four hour Emergency Department and theatre operation, and resulted in several meetings over the issue.

The Hospital’s Quality Co-ordinator developed a strong emphasis on risk management with the provider. Both were members of the Medication Review Working party and the Pharmacy Committee. Collaborative service improvements emerged from these groups that impacted on the way drugs, drug errors and incidents were managed.
The management of this provider was a shared one. The Manager had a service focus while the activities of the Manager of Finance were focused on financial matters associated with the supply of pharmaceuticals. At the ward level Nurse Managers were involved in the interface between patients, clinicians and pharmacists.

The pharmacy provider was always keen to improve its services to the Hospital. In 2001 they participated in a hospital quality awards program with a jointly developed paperless prescription system. Its participation was an indication of its commitment to the Hospital.

4.6.4 Billing

Both the Hospital and the patients were billed for pharmaceuticals. The Hospital was invoiced monthly for ward impress drugs used for patients during their stay. In addition, specialist drugs that were dispensed under prescription from the Pharmacy were also billed. Each month the Manager of Finance reported to the Board on the costs associated with pharmacy supplies and it was on these occasions that cost overruns would be discussed. Sometimes particular episodes of patient care became very expensive due to the nature of the drugs prescribed for their treatment. The rising costs of pharmaceuticals were a continuing issue because developments and costs seemed always to run ahead of the returns from the health funding bodies.

4.6.5 Monitoring

The Hospital had a Clinical Services Partnership Committee in the period 1998-2000. The Clinical Services Partnership included representatives from each of the Hospital's near-core clinical support providers. The business of the committee was generic because each of the three clinical providers was present. Ward level issues were discussed with each provider one at a time. After two years of relatively routine operationally-based discussions, the Manager disbanded the joint Clinical Services Partnership Committee. This decision was based on the committee’s assessment that the discussions could be more focussed with one provider in attendance. It was also felt that service specific meetings would avoid ‘wasting other’s time’. Separate
Clinical Services Partnership committees were created to focus on the needs of each provider and the Hospital's service issues.

A Pharmacy Clinical Services Partnership Committee was established in 2000. The Manager nominated a senior nurse to chair the group because they represented a key stakeholder group. One initial task was to implement the services key performance indicators that had been negotiated for the Service Agreement with the provider.

The Hospital also conducted an annual patient satisfaction survey to gather feedback on the quality of services provided to patients by the pharmacy provider. ‘In my experience, the pharmacy provider was genuine in its attempts to respond to patients’ feedback about their services. My sense was that the pharmacy provider took the feedback more seriously than the other clinical support providers. Being a family business, they had more to gain and they did not have corporate hurdles of the others to deal with,’ recalled the Manager.

The pharmacy provider reported medication reviews to a Medication Review Working Party. They also submitted monthly reports and invoices for drugs to the Manager of Finance. These were analysed and recorded. Monthly reports to the Board Cost Savings Committee, the Finance Committee and the Board, included a report on pharmacy expenditure. These reports were subsequently used in analysis and pricing for health funds negotiations by the Chief Executive and the Health Funds Contracts Manager.

The Manager reported annually to the Hospital’s Patient Care Council about the near core clinical support service providers. The results of the patient survey and quality improvement activities provided the focus.

4.6.6 Summary: Perceptions of Interorganisational Relationship Functioning

One burning issue that was unresolved in the research period was the one between the wards and the pharmacy provider. It related to the timing of services to the wards. There were frustrations about the frequency of ward rounds and the delivery of discharge drugs to patients. Ward staff were spending time waiting in the pharmacy
for patient discharge drugs. The Hospital argued this was non-productive time and that it was a service delivery responsibility of the pharmacy to deliver drugs to the wards even if they were for patients being discharged. Comments by one of the Nurse Manager reflected these frustrations:

They don’t report to anybody within the organisation, there doesn’t seem to be that impetus to drive it and move it forward … nothing changes, so it becomes acceptable practice … it’s too hard to change it, nobody will fix it, and

There are a lot of little things that don’t get fixed … all of those little things (have an) … effect on our organisation and it doesn’t assist us in our efficiency so we are wearing the cost within our organisation.

The Manager of Finance was the senior Hospital manager who expressed most difficulty with the Provider. On occasions he confided to the Manager that he found it hard to talk to them because he was angered by the negotiations. By this he meant that he was disappointed by his inability to find a compromise with the provider over pricing of pharmacy supplies. ‘His body language when he told me this was consistent with some one who had reached his tether. I felt for him. He felt hard done by and I think he felt that some mistrust had crept into the relationship,’ recalled the Manager. There was no doubt the relationship was strained by these discussions about money. ‘Whenever we talked about contractual matters - and not only with the pharmacy provider – interactions seemed to become harder. Conversations were tense and more formal,’ recalled the Manager.

The Manager reflected on these difficulties from time to time and on her own style compared to that of the Chief Executive. The Chief Executive was known to dislike conflict. He much preferred things to be informal and he appeared to the Manager to be very trusting. ‘Sometimes I used to think that this informality in the decisions process seemed to suit the providers. He could have a conversation in his office to sort things out. Some of the issues should never have arisen and it should have been possible for me to have sorted out,’ the Manager said.

On the other hand, the pharmacy provider was well accepted within the Hospital community. They had been there a long time, they were family orientated and this
seemed to be a comfortable fit with the Hospital’s culture. ‘We were all like a big family at the Hospital,’ commented the Manager. The pharmacy provider went to some effort to develop his business and expand services as the Hospital grew. In one year they participated in, and won, one of the Hospital’s quality awards. ‘I felt this was a great symbol of their integration in our business. They were pretty good at what they did and very professional,’ the Manager observed.

This completes the Manager’s narratives for the three near-core clinical support services. Her reflections highlighted events that relate to governance and contract management as well a range of operational issues referred to her by key stakeholders of the provider’s services. The Manager was not a direct consumer of any of these services and relied on feedback from others to monitor relationship functioning. She reported positive feelings about interactions at senior levels during her management activity. In the next three narratives the Manager has greater involvement. These are the peripheral non-core support services for some of which she was both relationship manager and consumer of the services.
4.7 Narrative Four: Food Services

4.7.1 Background

In 1995 the Hospital decided to outsource its food services. The service was outsourced to an existing external provider who had already formed a relationship with the Hospital since signing a contract in 1991 for Environmental Services. The Hospital signed a contract for management services similar to the one it had implemented for the Environmental Services. There was no formal tendering process and there was no specification of the services by the Hospital.

In 1995 the Hospital Executive considered the Food Services Department to be ‘in need of improvement’. Costs of running the department were too high and there were staffing and systems problems. The Chief Executive made a recommendation to the Board that the food services be outsourced and that the existing provider be granted the contract.

The outsourcing resulted in a number of redundancies and numerous changes. Employees recalled these changes as very unsettling and unpleasant (Payroll Manager). They were not consulted over the changes, separations were swift and the industrial action that accompanied them resulted in lost time over disputes. Senior relationship employees still recall ‘donning the aprons’ to help out in the kitchen so that the meals could be provided to patients.

In the late 1990s the Hospital purchased an adjacent hospital and the Food Services contract was extended to the additional site where these services had always been delivered internally. The integration of the two services was complicated by the need to refurbish the existing Hospital kitchen so that it could provide for the additional two hundred and fifty beds in the expanded hospital. This was a difficult time for the new Hospital staff that had always ‘looked over the fence’ at the Hospital’s unionised kitchen. There were further redundancies and attrition of staff was high because the integration of the services was slow. Many comparisons were made as the food service to patients was changed. Those who remembered the first outsourcing saw the process happen again. The additional patient meal requirements added a complexity
to menu planning because many of these patients stayed a long time for rehabilitation. They were rehabilitation patients as distinct from acute care patients who dominated the existing Hospital patients. Table 4-5 summarises the main features of the Food Services contract between 1995 and the end of 2001. The Food Service contract was renewed in 1998 and ended in December 2001.

Table 4-5  Features: Food Services Interorganisational Relationship

<table>
<thead>
<tr>
<th>Service:</th>
<th>Food Services: Patient meals, staff meals, retail coffee shop and staff bistro, special functions</th>
</tr>
</thead>
</table>
| Governance mechanisms: | Monthly Joint Review Meeting  
Contract for service |
| Start Date:       | 1995                                                                                     |
| Renewals:         | 1998                                                                                     |
| End Date:         | December 2001                                                                            |
| Clinical/Non-clinical: | Peripheral non-clinical support            |
| Financials:       | Fortnightly invoice based on patient occupancy                                           |
| Key Clients:      | Patients, doctors, staff                                                                 |
| Key Managers:     | The Manager, Dietician                                                                  |
| Structure:        | 1. Management Services by provider of Hospital employees  
2. Internal competency residing in employees  
3. Perceived hospital capability |

Source: Developed for this research

4.7.2  Developing the Service Agreement

Early after she commenced at the Hospital the Manager began to finalise the service contract for the renewal of the Food and Environmental Services contracts. The Manager reviewed all existing documentation about the negotiations with the Provider. Other executive members at the Hospital appeared quite unfamiliar and uninvolved in the discussions. The Provider representatives in the contract discussions also appeared uninformed because earlier discussions had involved another team, some key members of which had left the Provider in the meantime.
When the Manager first arrived at the Hospital discussions about food services contracted bed day rates had been in progress for six months. A bed day rate concept had been proposed between the previous Manager and the Provider and carried forward by an Acting Manager but it was never resolved.

There were months of discussion well beyond the contract end period about the proposed bed day rate for the Food Services contract. This was eventually agreed. However, knowledge of the ‘science’ behind its development had been lost over the period of negotiating time and the turnover of people involved in the discussions. The Provider told the Manager that the bed day rate was a new idea and not been tried anywhere else. This did not appear to worry her. She felt it appropriate to rely on the experts. The concept was to establish a variable pricing structure for the food service and take account of variations in occupancy and cost of goods:

The Provider maintained that the approach would enable a ‘win-win’. When occupancy was high they would benefit from volume sales, just as we would receive a reduction in cost to us. Given that the Hospital anticipated rising revenues, I thought this sounded fair. The Provider said a lot about efficiencies in work flow and practice and that appealed to me.

The Manager developed a revised service contract because she felt uncomfortable with the old contract:

It was a contract given us by the Provider contract and very biased towards them. I remember advising this to the Chief Executive and revising it to make it more balanced. I had some legal advice at the time that suggested I would be lucky to get the Provider to agree to my changes. Well they did!

Over time the relative costs of the food services had became difficult to identify because they had become integrated in the overall payments to the Provider. The Manager recalled:

When I asked the Provider for some detail on how the non-salary costs were broken up between the different components of the food service, it seemed they just came up with some estimates to meet the bottom line. My impression was forming that the Hospital had little detail
about what it was paying for and paid whatever the Provider asked for without much analysis.

The whole price side of the relationship seemed to be Provider-driven. We seemed to have no way to know what we should be getting for the payments that we made. We knew the salaries because the staff was on the Hospital payroll. Beyond this we just paid an amount.

One of the things I also noticed was that wages targets as set in the contracts had not been met. This was putting pressure on the contract price because the “take home” component of the contracted price was diminishing. The argument always seemed to be that Hospital should pay more because they were really our employees. The fact that the Provider promised savings and staffing targets seemed to get lost.

There was no formal specification to define the service expectations. The food service was a combination of patient meals, staff retail services, and functions. There was little transparency and no way to assess the operation. Negotiating a new contract was difficult in the absence of agreed detail and a means to evaluate the past services. By the time the Manager arrived, the previous contract had expired six months earlier.

The Manager seemed to be worried by this. She felt the pressure of the organisation to ensure that the Provider’s contracted services delivered value for money. It had not taken long for her to become aware of complaints. Indeed her predecessor had already highlighted to her the difficulties she had had trying to get co-operation and responsive participation from the Provider. Thus, the Manager became quite focused on trying to understand the costs, pricing and value of the services. The Manager came to her own assessment that the Hospital had exercised little management of the contract in the past.

4.7.3 Management of the Interorganisational Relationship

The Chief Executive and the Hospital Board represented executive management. The Manager was nominated as the contract manager and also had operational responsibility for the food services department. There was no dedicated contract manager for the outsourced services so that the Provider’s site managers reported direct to the Manager. The Manager also had ultimate responsibility for the
departmental employees who were all employed by the Hospital under an enterprise agreement negotiated between the Hospital and their union.

The role of ‘Contracts Manager’ did not capture the ownership she felt for the service or the employees. The Manager preferred to feel responsible for the Food Services Department. In addition, the Manager felt directly responsible for the various stakeholders and the patients’ satisfaction with the food service. This was the approach the Manager also took with her oversight of the Environmental Services that had earlier been outsourced to the same provider.

There was little involvement by the Chief Executive in the day-to-day operations of the contracted services. The chief executives of the Provider and the Hospital did maintain strong strategic relationships through a network of mutual interests and football. The Manager kept the Chief Executive informed about any issues but otherwise managed the delivery and contract autonomously. Matters relating to contract variation and price were discussed between the Manager and the Chief Executive. Table 4-6 summarises the main events between 1995 and the end of 2001 in the Food Services interorganisational relationship as recalled by the Manager. These events reflect the wide range of activities in which the Manager engaged in this interorganisational relationship.

**Table 4-6  Event Timeline: Food Services Interorganisational Relationship**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>The Provider and the Hospital sign food services contract that includes staffing reduction/cost savings targets. The Provider changes food services attributes such as portion control, plastic and disposables, menu.</td>
</tr>
<tr>
<td>September 1997</td>
<td>Bed day contract rate proposed for food services as part of contract review/renewal. Acting Manager continues contract renewal discussions.</td>
</tr>
<tr>
<td>April 1998</td>
<td>New Manager arrives. Bed day contract proposal reviewed and negotiated; Manager revises contract details to include clauses for stronger Provider accountability and more transparency. Provider signs contract for three years.</td>
</tr>
<tr>
<td>June 1998</td>
<td>The Manager advises that all staff appointments to be approved by the Hospital. The Manager also begins to monitor sick leave, annual leave liability and use of casual staff.</td>
</tr>
<tr>
<td>September 1998</td>
<td>The Hospital purchases an adjacent hospital. Provider assumes monitoring of extended Food Services while the operation continues as a separate cost centre under previous hospital staff management. Progressive handover planned. Separate payments to Provider using bed day rate</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>October 1998</td>
<td>The Provider commences modification of the previous hospital patient menu. The Manager requests Provider to prepare an integration proposal for the additional hospital and the Hospital food services. The Manager becomes aware of discrimination and harassment issues in the Hospital kitchen. Organises for mediation. Union becomes involved. Human Resources advisers become involved.</td>
</tr>
<tr>
<td>December 1998</td>
<td>Provider assumes management oversight of additional Food Services. Separate interim bed day rate for the additional services is agreed. Two kitchens operating. Provider takes over purchasing. Additional hospital management staff redundancies; one staff member transfers to Provider staff and retained at the Hospital. New Hospital staff dining room closes. The Manager expresses concern about workcover premium in food and environmental and calls for Provider to have a strategy to reduce injury and increase injury management.</td>
</tr>
<tr>
<td>December 1998</td>
<td>Still no response from Provider to Request for Integration.</td>
</tr>
<tr>
<td>February 1999</td>
<td>Kitchen refurbishment plans to enable closure of the additional Kitchen commence. Food Services production and distribution from two kitchens. Dishwasher dispute involving Engineering Department and Provider. Stripping stations dispute involves Provider, Engineering, staff and the union. Basket of Goods review shows Provider’s charges for food supplies are more expensive than three other providers in the market.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Disagreements and continuing discussions about staffing levels required for integrated Food Services. No Integration Proposal from Provider. The Manager attempts to “drive” for an integration plan. Meetings are held involving Human Resources advisers. Provider with help from Human Resources and external legal services produces a staffing profile for integrated food services. Anticipated savings from the integrated operation are built in. Provider Food Services Manager counselled about the change management required.</td>
</tr>
<tr>
<td>March 1999</td>
<td>Board Room disagreement between Provider and the Manager and Chief Executive over the integrated bed day rate. Provider leaves the meeting. Continuing concerns about workcover and injury management. Human Resources becomes actively involved in injury management with Provider managers. The Manager continues to apply pressure in this matter. Menu revision planning commences.</td>
</tr>
<tr>
<td>November 1999</td>
<td>Bed day rate reduced against refurbishment/rosters timeline. Union bans over dishwasher and stripping stations. Union refusal to adopt new rosters. Provider re-posts rosters. Provider claims reduction in bed day rate is unfair; claims repayment for additional labour costs because integration still not achieved. No Provider implementation of staffing changes. The Manager maintains Provider not addressing the management of Hospital staff – high injury, high sick leave, unproductive staff, and low morale. These factors contributing to the costs and low profitability of the contract for Provider. The Manager uses this situation to try to get Provider to address the staffing issues rather than paying more for the contract only to leave the issues un-addressed. Departing Provider State Manager confides to the Manager that Provider deliberately chose not to respond to the Hospital’s request for a proposal on integration. Provider Food Service Manager before departure suggests to the Manager that the lack of a services specification makes it difficult to know what the Hospital wants from its Food Services and what Provider should deliver. The Manager seeks Chief Executive approval to develop a specification for the Food Services operation. Chief Executive suggests on external consulting group. The Manager seeks Chief Executive approval to develop a specification for the Food Services operation. Chief Executive suggests on external consulting group. Provider becomes involved in refining the specification. New Provider National Manager promises to give more attention to the Hospital’s needs and contract and admits Provider central was complacent about the Hospital contract and that he has advised them so.</td>
</tr>
<tr>
<td>December 1999</td>
<td>Provider’s Food Services manager resigns to take up new Provider position; Chef becomes Acting Manager.</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>April 2000</td>
<td>Provider invited to quote on the specification. No competitive tender. New Food Services Manager appointed. Hotel background; no hospital experience/knowledge. The Manager supports appointment of expertise with customer service. Dieticians suggest Menu Monitors be restructured to report to them because they are without effective leadership. The Manager is ambivalent. Provider reminded about the specification and requested again to price.</td>
</tr>
<tr>
<td>May 2000</td>
<td>The Manager sets Food Services budget for new Provider manager (task normally done by Provider). Previous hospital staff compare pricing under Provider.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>The Manager and Human Resources Adviser become actively involved in supporting Provider managers with daily management of Food Services. EBA discussions involve Manager. Provider takes minor role because staff belongs to the Hospital. Union brings pressure on Provider managers and highlights the inappropriate use by Provider of casual staff. The Hospital is forced to convert casual staff to its permanent pay roll. Provider manager tells the Manager to let him run the business and suggests the Manager does not trust him.</td>
</tr>
<tr>
<td>December 2000</td>
<td>The Manager advises the Chief Executive that the Provider relationship and service is not working and that she feels there are problems that will not be resolved. This is not the first time she has had this discussion. The Manager suggests that a return to in-house service delivery would be cost efficient and effective. The Chief Executive indicates that he is close to convinced but is not sure how it will go. He values the Manager’s capacity to manage the in-house operation but fears it will be dependent on her staying at the Hospital. The Chief Executive invites the Manager to keep the conversation going with him.</td>
</tr>
<tr>
<td>May 2001</td>
<td>Manager establishes working group to review staffing issues and seeks suggestions from provider as to how work practices and systems can be made more efficient. Suggestions indicate that the integration plans proposed in 1999 have not been implemented. Performance management not occurring within the departments. Provider appears to want the Hospital to implement the staff changes – because the staff belongs to the Hospital’s. The Manager sees provider as having this role. The matter remains unresolved. The Provider’s manager tells the Manager to let him run the business and suggests the Manager does not trust him. The Manager seeks intervention from the Chief Executive to get provider to respond to the specification with a price.</td>
</tr>
<tr>
<td>June 2001</td>
<td>The Provider’s contract end date reached. The Manager advises the provider that contract is extended for six months to enable pricing and service delivery issues to be resolved. Provider appoints a new State Manager.</td>
</tr>
<tr>
<td>October 2001</td>
<td>Provider manager advises the Manager that he will sort out the contract and if the Hospital doesn’t come to the party the Provider will quit. The Hospital again invites Provider to respond to the specification.</td>
</tr>
<tr>
<td>November 2001</td>
<td>Provider responds with three pricing options. The Hospital assesses the options. Provider threatens to walk out early if the Hospital does not respond. Provider begins review of all invoices and queries decisions back to 1998/9. The Manager advises Chief Executive and Executive that the pricing options given to it are unrealistic and that the services should be returned to in-house. It is agreed. The Chief Executive advises the provider’s Chief Executive that it has decided not to continue with the Provider contract.</td>
</tr>
<tr>
<td>December 2001</td>
<td>The Hospital officially advises staff that the food and environmental services will be returned to in-house arrangements. Discussions commence on winding up the contract.</td>
</tr>
<tr>
<td>31 December 2001</td>
<td>Provider relationship ends.</td>
</tr>
</tbody>
</table>

Source: Developed for the research

The Provider’s contract was to provide management services of the food services function. This involved a small group of the Provider’s managers overseeing operations that were conducted by Hospital employees. The Manager called it ‘a sandwich model’ because it meant the Provider had the line management of her staff:
This model worried me because, as the Hospital’s representative, I still had ultimate responsibility for the staff on my payroll, working under my enterprise agreement. I interpreted this as meaning I had to keep an eye on what was happening to my staff. If anything was to happen in the future and the Provider was to leave, I would retain the staff and all the issues, liabilities etc associated with past human resources practices. The work cover worried me because this was not a responsibility that the Hospital could outsource.

The contract the Hospital signed gave the Provider responsibility to recruit and supervise the Hospital employees. It also separated the Hospital employees from the Hospital management and leadership. After a year of watching how this worked the Manager sent the Provider a memo and justified her decision to the site manager that the ‘care’ of the Hospital’s employees would have to be a shared responsibility. In the memo the Manager captured the intent of her deliberations about her responsibilities for Hospital employees:

The Provider was recruiting the Hospital employees for us as well as managing entitlements like leave accumulation, sick leave and injury leave, but I had to be assured that appropriate practices were in place. To this end I indicated that I would authorise all recruitment to new or replacement positions. I also monitored use of casual staff and leave liabilities.

There were other Hospital managers who had significant roles working with the Provider managed departments. These included the Senior Dietician, the Engineering Department Manager, the Infection Control Co-ordinator, as well as the Human Resources Adviser, Occupational Health and Safety Adviser and the Payroll Manager. These managers provided much support to the Provider site managers and the staff of the two departments.

In addition to these people, doctors, ward staff and Nurse Managers represented other stakeholders. These people had particular interest in patient meals because of the connection of food to patients’ care plans and rehabilitation. Acute patients with a variety of short term special food requirements had to have their needs met, not only in terms of texture, consistency, composition, quantity, and quality, but also timing. Variation around the specified needs of patients was rapidly identified and
communicated as complaints. Patients and their families were also quick to identify problems with the food. There were regular instances of differences of opinion about food composition for special dietary needs (such as diabetics), and these instances often became the basis of criticism of the food department.

The Provider appointed a site manager and an executive chef to look after the food services contract at the Hospital. In addition, there were a small number of specialist supervisors, making a total of four staff to oversee the work of more than one hundred Hospital food service employees.

Site staff received supported from head office account managers and specialist resources in the food, cleaning, systems and purchasing areas. The Provider’s managers were also responsible to train and supervise the Hospital employees. Site managers reported to the Manager and their own account manager. Feedback from these managers suggests that reporting to their provider manager was predominantly about financial performance against targets and was stressful. The stress arose from the requirements of the Provider to make savings or profit targets. For them this was in contrast to the emphasis from the Manager to meet service delivery and quality standards for patients, doctors and staff.

The Manager was keen to hear of initiatives to improve services and delivery systems, but

I was not so keen to respond with price increases when there seemed to me to be opportunities to fix problems and make savings. The Provider highlighted a number of service and systems problems - ward pantry supplies that were being eaten by staff rather than patients; staff ordering meals for themselves, in addition to patient meal orders. They complained about extras being ordered and food going to family and visitors of patients. They expressed concern about the cost of the food eaten by kitchen staff (a practice reputed to have been introduced by the Provider) and they complained about the cost of free biscuits and drinks for staff in the bistro.

The Manager recalled:
I remember tackling the free staff morning and afternoon food service food costs. The Provider claimed it was one way they could reduce expenditure. The service had always been included in the contract price, even though this was not documented. Other staff advised me that the service had been available a long time and its removal would not be supported.

There were some obvious solutions to this beyond cutting it out altogether. I suppose I hoped the Provider would come up with a proposal or a recommendation to help fix this problem. They seemed unable to work to do this. I worked through some ideas with them and we eventually reduced the times when free food was available and the line of product available.

As with lots of other things there was nothing written down anywhere to say how the food service was to be structured. The Provider continued to be frustrated by the systems it worked within but they seemed not able to take the initiative to address problems.

The Provider seemed unable to implement change:

I could see no evidence of improved work practices; none of the initiatives that it talked about … just complaining about problems! I found myself making suggestions to them about what could be done. I used often to contemplate whether my expectations of them were too high. But this was a management services model and they presented themselves as the management experts. I knew I wasn’t the expert but I was certainly looking to the Provider to be such. I am afraid I rarely saw any ‘smarts’. I wasn’t prepared to just add more money on top of things because they had systems problems. I was always aware that the Hospital brought them in to ‘clean up a mess’ and the feedback I was getting from above me was about cost control and customer service. These had become my business drivers. It became difficult for us all.

The Manager formed a view within twelve months of taking up her role that the Provider’s food services arrangement was not working as well as it should for the Hospital and that consideration could be given to bringing it back ‘in-house’. The Chief Executive continued to support the relationship despite representations from the Manager:

I came to understand that the service provider was here to stay, and that any suggestion to him that things could be delivered ‘in-house’ better, was not going to be accepted. I felt I was told to learn to accept it.
A key Hospital business goal was patient satisfaction. As a support service rather than a core service, the Manager worked under the pressure of the expectation of cost containment. This led to pressure to keep the contract costs under control. The Provider’s complaints about prices and profits caused an unresolved tension. This tension was contributed to by the Manager’s expectation that as management experts the Provider would be able to implement systems and processes that were efficient. This expectation led to a close monitoring as the Manager recalled:

I was quite aware of the Hospital’s emphasis on cost and customer service. This was enhanced by regular complaints that were directed to me. They came from doctors, dieticians, patients, family members, executive members, nurses – from all over. Everybody had something to say about food; everybody is an expert! The complaints kept me on my toes and on the Provider I guess. I became quite defensive about the department. I knew that they were trying hard. Sometimes I felt like food complaints served to divert attention from other problems. I learned how to put complaints into perspective by relating them to numbers of patients. This made the ratio of complaints quite low!

Site managers and the Manager handled complaints. The Manager referred to this:

I would write letters to patients and family members to apologize and explain. I would have complaints investigated and I would visit patients to talk with them. Staff would come up to me and tell me about food problems. I would get anecdotal comment at meetings. Sometimes it would seem to come from everywhere! Sometimes it was made a joke. I began to find this difficult and frustrating.

Sometimes I felt that the Provider would move between ‘well the problems are really the Hospital’s because they are your staff we are managing’, to one manager who said ‘why don’t you just let me manage because we are the experts?’ It’s an awful thing to say, but by the time it got to this last manager I, and others knew, that unless the Provider managers were given a lot of support from within the Hospital, the service delivery from the two departments would have collapsed.

The Provider’s site managers met very regularly with the Manager because she was conscious of stakeholder comments and did not enjoy responding to complaints:

Even at the Board level I would have complaints and comments passed on to me – ‘what are you doing about …?’ It was hard work.
Everybody thinks they are an expert in food service and I think it is because everybody knows something about food! I was always conscious about the glowing comments about nursing and when anybody wanted a bit of fun it was food that was the basis of a story recalled. Even one of the young Finance Department guys had a go with a derogatory cartoon at a meeting one day. I was not impressed!

The Manager had frequent meetings and monitoring of the food and environmental services activities. This was largely because she felt responsible for the services outcomes:

I felt a lot of pressure to improve food quality, services and reduce complaints. One complaint often seemed to acquire enormous focus. I remember carrying around figures in my head about the number of plated meals per day and month so that I could relate the complaints to some sense of frequency rate! I found this very helpful to maintain some context and it was a useful ‘defence’ for my departmental guys who tried their hardest.

The Manager felt that there was often confusion over authority:

Half way in to my time at the Hospital I became aware of ‘game playing’ wherein my own hospitality staff would suggest they had been told by the Provider’s management that the Hospital management would not let them have new or adequate equipment, such as cutlery, trolleys. I would tell them that I had not received any proposal and, in any case crockery etc was included in the budget. They should go and buy what they needed. This happened several times. Other times they would tell me – or worse the shop stewards – that I would not allow them to have more staff.

When the Manager increased her contact with the Hospital staff it seemed to exacerbate game playing. She commented about this:

The Provider’s managers wanted me to be seen and involved with the staff. I enjoyed this but I found if I got too close I would start to receive comments and requests for things that related to the Provider’s operations. A couple of times I had shop stewards questioning why the Provider had to be here and wouldn’t we be better off without them. This was difficult and I would find myself backing away to put distance between the Provider management and the Hospital staff. Sometimes, between Engineering, who had always been against outsourcing and didn’t like the provider, Human Resources and some of the nursing, I felt like I was defending a situation nobody wanted. I
still felt that outsourcing should work, albeit I was not sure that the provider model was the right structure.

The lack of an effective conduit to the Hospital management and authority was the perfect opportunity for the union to gain a position of influence. Successive site managers appear to have succumbed to union managed supervisors. Union membership within the kitchen and amongst the Ward support services was very strong. This made the Hospital vulnerable to union unrest and there were times when shop stewards extended system level problems to the Hospital site. The Manager recalled:

At one point I felt that the shop stewards had become pseudo supervisors. I had anecdotal reports that employees were pressured over rosters, union membership, overtime and time sheets. It seemed that the management was unable to get on top of this. Shop stewards told me that staff would come to them because the Provider’s management would not give them what they needed to do their jobs.

It certainly meant that when there was trouble brewing in the system, my staff could be called on to participate. It’s a pretty daunting thing to find a hundred of your staff sitting in the Bistro refusing to go back to work and knowing the patients upstairs are waiting for a meal.

It also meant that when we wanted to do something new, like put in a new dishwasher, we had to tread very carefully. There was an occasion when I discovered that the shop stewards had placed bans on the stripping stations. When I discovered this, the bans had been on for more than a month. The Provider had not told me. It was only because they wanted to be compensated for having to use casuals to cover the shift that I found out! I mean you have to ask why this was allowed to go on for so long. I could never fully understand the way the Provider managed but I could understand why they might be losing money.

4.7.4 Billing

The invoicing process was a monthly process undertaken by the Payroll Manager with the Finance Department. Throughout the study period the services were paid for on a bed day rate that was calculated after the Hospital’s occupancy was known. The Payroll Manager recalled:
It was quite a messy process reconciling that because there were various exclusions in the contract. For example we picked up the workcover levy, they picked up the makeup pay in the first ten days and we would pick up the other workcover as we would get that reimbursed from our insurer that was all quite messy really.

It would have been easier to say, we will pay the wages, we agree the contract amount and all they would have to do is pay the difference whatever it was.

Over time the bed day rate seemed to become very cumbersome and the Provider began to feel that it was not working in their favour, particularly when occupancies were low. This was despite the fact that it was the Provider who suggested this type of approach.

4.7.5 Monitoring

A Monthly Joint Review Meeting was held. The Manager, Senior Dietician, a representative of the nursing areas, the Provider’s site Manager of Environmental Services, and representatives from the Provider’s head office attended this meeting. The aim of the meeting was to receive a report on issues over the previous month, to discuss objectives, receive reports of quality assurance activities and monitor progress of projects. The meeting combined consideration of the Environmental Services delivery and the linen delivery. It was a long meeting lasting more than an hour. Nurse Managers were often absent for part of the meeting. The Manager recalled:

We had several attempts to make the meeting concise and issues-based but it never really achieved this. The Provider’s site managers seemed to take this as their one opportunity to describe to their head office supervisors all of the previous month’s activity. The Hospital representatives had heard it before because they had been involved directly with the service during the time. I often found some advantage having the Provider's senior people in attendance. It resulted in useful support and pressure at times to get responses from the site managers. There were so many frustrations around getting things to change. It took so long. Some things just never got changed despite repeated discussion.

The Manager and two or three other key Hospital stakeholders represented the Hospital at these meetings:
Not long after I came the Nurse Managers on this committee decided that their membership should be reviewed. They were not convinced of the value of the meeting and the time taken. The meeting tended to be a report about things we already knew rather than issues based. The meeting was a ‘protected opportunity’ for the site managers to report on their own activity in front of their head office management.

Much of the real work happened outside these meetings because there was such a close working relationship that developed between the Provider site managers, the Manager and others.

Every twelve to eighteen months the Hospital conducted a Hospitality Survey. Patients were asked to provide feedback about the cleaning, patient support services and the food services. The information from these surveys was given to the Provider for follow up and feedback. On a couple of occasions the Manager held a meeting with the staff to provide the feedback and she used this as an opportunity to get feedback from the staff. The Manager would also attend staff meetings periodically to report on hospital activities and to touch base. Without this she had to rely entirely on the provider to communicate with the staff.

Every month the Manager reported on the financial performance of the outsourced food services to the Board’s Cost Savings Committee. The Manager used this report to highlight contract issues and pricing issues. Eventually the Committee moved to support the Manager in her recommendations to the Chief Executive that the contract be terminated.

4.7.6 Summary: Perceptions of Interorganisational Relationship Functioning

There were many complexities in this interorganisational relationship. The Manager spent a large portion of her time on the relationship. It was complicated by the service delivery structure wherein the Manager felt she retained responsibility for the Hospital employees. During the study period she made a conscious decision to exercise this responsibility. She may have done this in a way that led the provider to perceive that their autonomy and authority was called in to question.
The regular turnover of the Provider’s site managers meant there was a regular induction of new management. The Manager discussed improvements and change with the Provider, but she continued to perceive that implementing such change was difficult. She perceived that the Provider resisted her requests for change. Often she discovered that what she had requested happen, in fact did not. One example of this related to the provision and replacement of crockery.

The Manager was conscious that the Hospital management, nursing staff, as well as patients, devalued the food services because it was outsourced. Some staff remembered the ‘good old days’ when the Food Services were delivered in-house. There was pressure on the Manager to have a memorable food service and few complaints. Pressure was compounded by the sense that other people, such as employees and patient families, thought they knew how to deliver the service better. The Manager often exclaimed that ‘everyone thinks they are an expert in food because they all know a little about preparing food!’

One of the most frustrating and disappointing things for the Manager was the persistent Hospital view that enabled the Food Services to be referred to as ‘outsourced services’ on the organisation chart:

These people had no identity beyond the status of being outsourced. I tried for years to have this fixed. On one occasion when the organisation chart was being updated before an accreditation audit I tried to have the food services department displayed. One of the senior executives suggested I was trying to empire build! I still find that amazing. The food and environmental services groups comprised probably two hundred Hospital employees. I thought a bit of recognition might be a reasonable idea!

Food Services employees felt undervalued and frustrated that they were not recognised. One of them commented to the Manager:

I think we had to be a bit overzealous in getting things done because the provider’s senior management was not in a frame of mind to listen to reason most of the time. You would go to meetings and you would organise things, and you were just hitting your head against a brick wall. Nothing was getting done.
In comparison to her management involvement with the near-core clinical support services relationships, the Manager was very involved with the Food Services provider. She reflected:

It is probable that I was too involved. At the time I felt responsible for the Hospital employees and I felt that the provider was not managing well. There is no doubt the site managers did their best. Considering my constant pressure on them to change and improve, some of them made great efforts. My view and others, was that they were not well supported by their own head office. There were times that the site managers became caught between my demands and those of their own organisation. I wanted better processes, better product and good, safe systems for my staff. I wanted them to ‘own’ responsibility for staff safety so that my workcover premium, for instance, could be controlled. It was the highest of any department in the Hospital when I went there. The provider did little to address the situation and just expected us to pay for this and additional staff to cover the injured. I had to find a way to address this.

Overall I think I was not too popular with the provider and I guess I can understand. When the relationship came to an end I felt very responsible for this. But I did have mixed feelings. The staff and union were very happy. The Board was pleased because they liked the savings and the thought that quality could be better assured. The Chief Executive was impressed albeit he was maybe a little disappointed that one of his initiatives had come to an end. But he had taken his time to be convinced.

I was exhausted by it all. I was aware that the provider was not at all happy. I think there were lots of misunderstandings along the way. I definitely think that the provider took me, or us, for granted. I suspect they thought that the relationship between Chief Executives would carry them through.

This interorganisational relationship ended after six years. The Manager had mixed feelings about her approach to managing the relationship given the way it ended. She expressed this concern. While the decision to return the Food Services to in-house arrangements was widely supported by Hospital employees, the Manager continued to reflect on her interactions with the provider and to contemplate what had happened and what alternative approach she could have taken. She continued to feel that the failure was linked to the particular structure of the service delivery which placed her between the provider and her staff. This was compounded by the added pressure she felt to improve the performance of the service. Her assessment, along with similar assessment by others, was that the provider seemed unable to address this. Ultimately
she and other managers decided that they could deliver the service for themselves better than the provider. Personal relationships broke down and the provider decided that it could no longer remain in the relationship with the Hospital.

When the Food Services delivery wound up, the Environmental Services delivery also ended. The Environmental Services was delivered by the same provider as the Food Services. While it suffered the same fate as that relationship the Manager sometimes reflected on why this had to happen. ‘The service was not ‘broken’ like the food service but it ended too. I always worried about this. Along the way the provider either assumed that this service had to end too – even though this had hardly been discussed in these terms. It seemed to me that the provider took it very personally and pulled out of all relationship with the Hospital rather than stay on in any capacity,’ reflected the Manager.

The following narrative is about the Environmental Services. This service was delivered by the same provider who delivered the Food Services. The events recalled in the next narrative occurred during the same period as the Manager concurrently managed the interorganisational relationships.
4.8 Narrative Five: Environmental Services

4.8.1 Background

In 1991 the Hospital outsourced its cleaning services. In 1995 there was an extension of the scope of services to include provision of a new ward support service to nurses on the wards. The contract changed to the provision of Environmental Services.

Within 18 months, and following a decision to adopt a different nursing model (patient focused care) most cleaning staff were retrained to meet the requirements of a new multi skilled ward support role. Multi-skilled ward support service employees were the first in Australia to deliver this new support service.

Table 4-7 below summarises the main features of the Environmental Services contract.

Table 4-7 Features: Environmental Services Interorganisational Relationship

<table>
<thead>
<tr>
<th>Service:</th>
<th>Environmental Services: Ward support services, waste management, cleaning, linen supply, external linen services co-ordination</th>
</tr>
</thead>
</table>
| Governance mechanisms: | Monthly Joint Review Meeting  
Contract for service |
| Start Date: | 1991 cleaning  
1995 extended to ward support services |
| Renewals: | 1998 |
| End Date: | December 2001 |
| Clinical/Non-clinical: | Peripheral non-clinical support |
| Financials: | Fortnightly invoice based on fixed price |
| Key Clients: | Ward nursing teams, patients |
| Key Manager: | The Manager |
| Structure: | 1. Management services of Hospital employees  
2. Internal competency in Hospital employees  
3. Matrix management structure at ward level  
4. Perceived hospital capability |

Source: Developed for this research
The Provider was instrumental in working with the Hospital to create/define the new ward support services role that became a mix of cleaning, food delivery, orderly and nurse/patient assistance. Only a few of the original Hospital employees remained in the traditional cleaning positions rostered to cleaning services in the general/public areas. The ward support services worked on the wards as members of the new patient service teams. On a daily basis they were locally supervised by nurses but in the line structure they reported to the Provider’s Environmental Services Manager.

In the late 1990s the Provider expanded its Environmental Service provision to include the newly acquired adjacent campus when purchased by the Hospital. The ward support services model was extended into these new areas of the Hospital over a twelve month period because of the training required to upgrade the skills of the employees.

4.8.2 Developing the Service Agreement

The Hospital contracted with the Provider without a specification and without going to formal competitive tender. The decision about outsourcing was the first in a number of outsourcing decisions made by the Board in the three-year period 1992-1995.

The cleaning contract was to deliver savings through systems efficiencies. These were built into targets set within the contract. The Provider took responsibility for managing more than one hundred the Hospital employees, all recruitment, supervision, training and safety of these employees, supply and maintenance of equipment, purchase of consumables and training in their safe handling, quality assurance activities.

The Provider contract price included the cost of the Hospital employee wages (approximately eighty-five percent). The Hospital was invoiced monthly for the full price of the service. The Hospital employees’ wages bill was deducted from the total service costs to calculate the net cost for invoice payment to the Provider. This approach enabled the Provider to report a higher business turnover to its shareholders. The contract was renewed twice and ended in December 2001.
4.8.3 Management of the Interorganisational Relationship

At the Chief Executive level, involvement in the day-to-day operations of the contracted services was negligible. The Manager kept the Chief Executive informed about any issues but otherwise managed the delivery and contract autonomously. Matters relating to contract variation and price were discussed between the Manager and the Chief Executive.

The Environmental Service Department consisted of more than one hundred Hospital employees in 2001. Two provider managers managed these employees. Eighty percent of the employees worked as ward support services providing assistance to nursing teams. On a daily basis they worked within the nursing teams. The Provider’s managers looked after rostering, budget and all training and quality standards maintenance. They provided central co-ordination and oversight for the Nurse Managers. This created a matrix management that was always a difficulty and an excuse for issues and problems that arose throughout the service provision.

On some wards the model worked well. Elsewhere Nurse Managers struggled to effectively supervise ward support services employees. Nursing staff and the Infection Control Co-coordinator would comment and critically evaluate the quality of cleaning, the behaviour and standards of the ward support services employees. They reported and complained to the Provider manager and the Manager.

There was regular discussion about whether ward support service supervision should be returned to the nurses or left as a central support service. The Manager was conscious of the Hospital’s contractual obligations to the Provider and was aware that the ward support service model was a cost effective one.

At the Hospital the matrix model of management was derived from an original concept of a multi-skilled support employee, who could be moved to areas of highest need. This model, thus, represented a flexible resource that guaranteed cost effective service support. The model was open to criticism in part stemming from nurses who felt a sense of inadequate control. The Manager also felt that the tensions were an
indicator of poor management relationships between the external service provider and the Nurse Managers.

There were anecdotal reports that the ward support services employees confused the Nurse Managers and the Provider managers. Sharing the management of a resource was always difficult. Nurses wanted more control to exercise rosters and duties. As the Provider’s profitability was built into the way it managed rosters, there was always going to be this tension.

The Manager was both the contract manager and the line manager of the Provider’s managers. The Manager exercised her line responsibility in the same way that she did for the Food Services contract. This occurred as the Provider was managing Hospital employees. It resulted in tighter daily control by the Manager and placed the Provider’s managers in another matrix with their own Hospital Account managers. As Table 4-8 shows the Manager recalled numerous events in which she was very involved in daily decision making about the interorganisational relationship. The Manager assumed responsibility for industrial negotiations, particularly those relating to enterprise agreements, in full knowledge that the outcome of these negotiations would also affect the Provider’s contract price. In addition to these roles the Manager also had a relationship management role. The Manager spent considerable time communicating the contracted arrangements to other managers and staff within the Hospital.

Table 4-8 Event Timeline: Environmental Services Interorganisational Relationship

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>The Provider and the Hospital sign Environmental Service contract. The Provider implements Ward support service model on the wards. Cleaning contract changes to include ward support services and cleaners.</td>
</tr>
<tr>
<td>November 1997</td>
<td>Acting Manager continues contract renewal discussions.</td>
</tr>
<tr>
<td>April 1998</td>
<td>Manager arrives. Continues contract renewal discussions. The Manager revises contract details to include clauses for stronger accountability and more transparency. The Provider signs contract for three years.</td>
</tr>
<tr>
<td>June 1998</td>
<td>The Provider’s Environmental Services manager replaced on the Manager’s request.</td>
</tr>
<tr>
<td>Month</td>
<td>Event</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>September 1998</td>
<td>The Hospital purchases an adjacent hospital. The Provider assumes direct line management of Environmental Services. New hospital staff transferred to Hospital payroll. The Manager continues requests for operational and performance information about the new hospital’s environmental services.</td>
</tr>
<tr>
<td>November 1998</td>
<td>The Provider contract price amended to include new hospital areas. Up until this time paid at cost. New hospital Environmental Services management staff redundancies. The Manager expresses concern about work cover premium in Environmental Services and calls for the Provider to have a strategy to reduce injury and increase injury management.</td>
</tr>
<tr>
<td>December 1998</td>
<td>Still no response from the Provider to Request for Integration. Decision to retrain the new hospital’s Environmental Services staff to enable ward support services model to be implemented.</td>
</tr>
<tr>
<td>May 2000</td>
<td>Environmental Services Manager resigns. Continuing concern that the Provider has not appointed a new Environmental Services Manager. The Provider tries various means to identify a replacement but the Manager does not accept what the Provider puts forward. The Provider disputes proposed revised contract price for Environmental Services. The Provider continues to express concern that it is not making money.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>The Manager and Human Resources Adviser become actively involved in supporting the Provider managers with daily management of Environmental Services. Industrial discussions involve the Manager. The Provider takes minor role because staff belongs to the Hospital. Union brings pressure on the Provider managers. Union highlights the misuse by the Provider of casuals. The Hospital forced to convert casual staff to its permanent pay roll.</td>
</tr>
<tr>
<td>December 2000</td>
<td>The Manager advises the Chief Executive that the Provider relationship and service is not working and that she feels there are problems that will not be resolved. This is not the first time she has had this discussion. The Manager suggests that a return to in-house service delivery would be cost efficient and effective. The Chief Executive indicates that he is close to convinced but is not sure how it will go. He supports the Manager’s capacity to manage the in-house operation but fears it will be dependent on her staying at the Hospital. The Chief Executive invites the Manager to keep the conversation going.</td>
</tr>
</tbody>
</table>
June 2001 | The Provider current contract end date reached for both Food and Environmental Services. The Manager advises the Provider that contract is extended for six months to enable pricing and service delivery issues to be resolved.

August 2001 | The Provider appoints a new State Manager. The Provider advises the Manager that he will sort out the contract and if the Hospital doesn’t come to the party the Provider will quit. The Provider begins review of all invoices and queries decisions back to 1998/9. Seeks repayment for price adjustment made by the Manager in absence of a replacement manager. The Manager advises Chief Executive and Executive that the pricing options given to the Hospital are unrealistic and that the services should be returned to in-house. It is agreed.

November 2001 | The Chief Executive advises the Provider Chief Executive that it has decided not to continue with the Provider contracts. Discussions commence on winding up the contracts.

December 2001 | The Hospital officially advises staff that the Food and Environmental Services will be returned to in-house arrangements.

31 December 2001 | The relationship ends.

Source: Developed for this research

The Payroll Manager and the Human Resources Advisor assisted the Manager with aspects of the contracted services. The structure of the Environmental Services provision meant that eighty five percentage of the contract price was made up of the wages and salaries of Hospital employees. Interview notes with the Payroll manager indicate the significant involvement with Hospital employees advising on queries and complaints about pay, leave and entitlements. The Provider’s site managers referred staff, or indeed their staff went directly, to Hospital managers for this information and advice. The levels of frustration reported by this manager stem from a sense of the abdication of this management responsibility by the Provider’s site manager.

The Human Resources Adviser spent considerable time with Environmental Services staff. In the final year of the contract, and after the Provider failed to replace its departmental manager, the Human Resources Adviser and the Manager spent much of their time assisting the remaining supervisors to run the department. The Manager recalled:

The Human Resources Adviser told me that he spent more than twenty five dollars of his time on staffing matters that the Provider should
have been able to handle. The lack of effective leadership enabled the union shop stewards to stir up unrest among the staff.

### 4.8.4 Billing

The Environmental Services contract was a fixed price contract and invoices were received monthly at the same time as the Food Services contract. Eighty five percent of the contract price was comprised of wages and salaries. These costs were for staff on the Hospital payroll. The provider purchased all consumables and engaged subcontractors to cover pest control, general waste removal, sanitary services and infectious waste disposal. The cost of these subcontractors was not transparent to the Hospital part of a fixed amount over the wages and salaries component. This meant that over time the provider began to make claims to the Manager for contract price increases to cover escalating costs. The Manager perceived that the provider could make savings through more effective staff rostering, management of sick leave and injury and in so doing recover some of these savings. As a consequence, she regularly resisted the provider’s claims for contract price increases.

### 4.8.5 Monitoring

A Monthly Joint Review Meeting was held. This meeting was a combined meeting with the Food Services representatives. The aim of the meeting was to receive a report on issues over the previous month, discuss objectives, receive reports of quality assurance activities and monitor progress of projects. The meeting combined consideration of the Environmental Services delivery and the linen delivery.

Beyond this monthly meeting there were regular audits of the cleaning and an annual hospitality survey of patients. The Hospital’s Infection Control Co-ordinator undertook fortnightly spot audits in the wards, theatre and food areas with the Provider’s site managers. Reports were prepared and follow up actions undertaken to redress problems. The audits were taken seriously and often led to refresher training for staff. The Manager also completed ‘white glove walk-arounds’ with the Environmental Services manager to check on the cleanliness of patient and general areas. This was also a way for her to maintain contact with staff and to chat to nurses.
and other stakeholders of the service. From time to time there would also be the opportunity to chat to patients to assess their satisfaction with the hospitality services.

As noted earlier within the Food Services narrative, every twelve to eighteen months the Hospital conducted a Hospitality Survey. Patients were asked to provide feedback about the cleaning, patient support services and the food services. The information from these surveys was given to the Provider for follow up and feedback. On a couple of occasions the Manager held a meeting with the staff to provide the feedback and she used this as an opportunity to get feedback from the staff. The Manager would also attend staff meetings periodically to report on hospital activities and to touch base. Without this she had to rely entirely on the provider to communicate with the staff.

The Manager also reported annually to the Hospital Board Patient Care Council. The results of the Hospitality survey and quality improvement activities provided the focus. The Manager also provided monthly reports to the Board Cost Savings Committee on financial matters relating to the service contract and the Department’s financial performance.

**4.8.6 Summary: Perceptions of Interorganisational Relationship Functioning**

The management services provided through this interorganisational relationship was subject to two major difficulties. Considerations about the services were regularly overshadowed by discussions about the Food Services provision. The Manager recalled:

> I believe this was a shame because the problems in the food area dominated our discussions, right up to the end when the relationship with the provider ended. There really was no reason to cease this particular service contract, in my view.

However, the major problem was that throughout the relationship, there continued to be complaints from some of the Nurse Managers about their frustrations with the provider’s service delivery model. This frustration resulted from a sense that they did not have ‘control’ of the ward support services employees. They did not support the
central management of employees who worked, at local levels, under nurse supervision. They regularly associated central management of these ward service employees with difficulties at the local level. The service delivery model provided for a matrix management structure of ward-level supervision with central department accountability. Perceived problems with the matrix structure were exacerbated by central management being with an external provider who, in turn, was responsible to the Manager.

There were a number of reviews of the ward support services during the research period. These were encouraged by the nursing division. Despite these reviews, there was no change made during the research period. The Manager, the Chief Executive and the Provider each agreed that the arrangement was the most efficient. When evaluated through broad staff and patient surveys, the results supported their views as the Manager recalled:

The frustrations were really local, truth-be-known, because the model worked very well in those areas where team leaders engaged in supervision and did not mind the line authority being elsewhere. I think it was easy for some of the nurses to blame somebody else for Ward support services problems.

Throughout the period of the interorganisational relationship the Manager, the Human Resources Adviser and the Payroll Manager, all expressed concern about high absenteeism in the service. They put pressure on the provider to address these problems. High levels of casual staff were used for replacement so that the services could be maintained. They regularly offered to assist the provider. It was the Human Resources Adviser who spent much time with the provider’s site manager in attempts to build his capability so that he could better manage his service. The Manager always thought it was somewhat ironic that the Hospital supported one provider to help another provider so that it could have an effective environmental services delivered.

Relationships with the provider’s site managers were very amicable who were well integrated with the broader Hospital community and, thus, seemed like part of the Hospital. Unlike the food services, there was much less turnover of the provider’s site
managers in environmental services. This process of socialisation was facilitated by ‘sharing’ the management of the ward support services employees between the site managers and the Nurse Managers. The Human Resources interorganisational relationship was similarly characterised by strong social ties that developed through close working routines. The Manager’s reflections on this interorganisational relationship follow in the next narrative.
4.9 Narrative Six: Human Resources

4.9.1 Background

Table 4-9 summarises the main features of the outsourced Human Resources services relationship.

Table 4-9 Features: Human Resources Interorganisational Relationship

<table>
<thead>
<tr>
<th>Service:</th>
<th>Human Resources Services: Advice, Workcover management, OH&amp;S co-ordination, legal advice, industrial relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Date:</td>
<td>1995</td>
</tr>
<tr>
<td>Renewals:</td>
<td>1999</td>
</tr>
<tr>
<td>End Date:</td>
<td>June 2002</td>
</tr>
<tr>
<td>Clinical/Non-clinical:</td>
<td>Peripheral non-clinical support</td>
</tr>
<tr>
<td>Financials:</td>
<td>Fixed price contract; monthly payments; legal fees, some training and project consultancy paid as additional fees</td>
</tr>
<tr>
<td>Key Clients:</td>
<td>Hospital line managers</td>
</tr>
<tr>
<td>Structure:</td>
<td>Central advisory team accessed by Hospital line managers as required; developing in-house capability; educative model</td>
</tr>
</tbody>
</table>

Source: Developed for this research

The Human Resources function at the Hospital was managed centrally in the traditional way until in 1994 when the manager at the time put a proposal to the Chief Executive to change this. It was proposed that Human Resources management would be better aligned to the new patient focused model of care if it was devolved to line managers. The proposal was accepted. The manager resigned his position taking some employees with him. He established a new organisation that was engaged by the Hospital’s Chief Executive to provide human resources support and advisory
services back to the Hospital. The old Human Resources Department was closed. Those employees who did not transfer to the new organisation were made redundant. The provider was awarded the contract for three years 1995 - June 1998. During this period it implemented the devolved approach to Human Resources management.

There were three Provider managers between 1998 and mid-2002. There was also a succession of administrative support officers and Occupational Health and Services advisers. The longest appointee was the Workcover Adviser who left the Provider only six months prior to the relationship with the Provider ending. One adviser left in late 1998. There were two rumours as to why. One related to the individual's own relationship with the Provider. Another suggests that the person had only ever been acting in the role, and probably did not have the capabilities required for the complex times at the Hospital. The Manager recalled:

I became aware the site manager was going well after the decision seems to have been made. I recall wondering what the process would be with respect to a replacement. I had been consulted about such changes with other outsourced providers earlier in the same year. As it turned out this manager was not replaced for a while so managers accessed the Industrial Relations Adviser if they required support. I had no role in the selection or the appointment.

During the study period there was a split between the two partners. It was rumoured that the partner who had once worked for the Hospital left because of irreconcilable differences with his business partner. Following his departure there was a succession of departures by other employees who were closely associated with him. The Manager recalled expressing concern about the continuing capacity of the Provider to deliver adequate support to the Hospital contract. Services began to change for the Hospital after the split. There developed a focus on ‘billable hours’ that was not acceptable to the Manager after the way the relationship had worked up to then. The quality of the service support declined and some Hospital managers began to observe that they could do things for themselves.

At the same time the Chief Executive engaged the old Hospital partner, now on his own and re-established, for occasional projects. The Manager became troubled by remaining partner’s was orientation to bill for services once provided as part of its
services. This was exacerbated by the growing comments from Nurse Managers that they felt they could do things better themselves. The Manager began to explore the market place for other providers and recalled:

It was interesting this time. I sensed that the Chief Executive, who on previous occasions had vehemently supported this provider relationship, did not seem so concerned this time. He had always resisted suggestions by other executive members to bring human resources in-house. He and I actually ‘joined forces’ once when the issue was raised. I in fact supported the outsourced model because I thought the devolved service approach worked well. However after the split, and I suspect because he was trying to help out his old mate who was now on his own, he came to agree to a short list competitive tender for the human resources services when the existing contract expired.

The existing provider was advised that I was developing a scope of works and that he and another would be asked to submit a proposal for the service. I guess I felt a bit like the ‘bad guy’ again, especially as it was only six months after the food and environmental services contracts ended!

It didn’t go well for the provider. He came in to meet with the Chief Executive and a couple of executive members and me, but he essentially ‘threw in the towel’. He was aware that his old partner had re-established himself with the Chief Executive and that I had also been talking with him in order to implement work that he had been engaged to do. There was an aggressive atmosphere in the room. He said what he thought of the situation and left basically without attempting to put any case.

This led ultimately to the change of provider in June 2002 as the other partner put together a new team which resumed the services delivery. Those who had been there before stayed on. The Manager reflected often on this, as did other managers:

I suspect none of us anticipated this quite so clearly. It was a bit like going back to something we had had before and yet we were all at the stage of looking for more innovation from our Human Resources provider. It struck me then that the Chief Executive had perhaps supported the ‘market testing’ with a view to taking back his old mate and maybe I went along with this. It wasn’t a pleasant thought to think I had not seen this!
These thoughts led the Manager to reflect on her relationship with the Chief Executive and particularly about how she felt ‘caught’ in his network of relationships. She thought that she was trying to do her best for the Hospital’s services delivery. This was when she quietly concluded that he had his ‘mates’ and these relationships were formidable connections if ever others wanted to do anything differently. She realised what an achievement it had been for her to get the Chief Executive to finally agree to end the food and environmental services contracts.

The Manager thought back to a meeting that the Chief Executive had organised with the Chief Executive of that company. They had been to the same school and he was involved in the football sector. ‘I felt small!’ she recalled. ‘It was only a short meeting at which they did a little recalling in front of me and then my Chief Executive told him that the contract was in trouble but we would try to work it out. I thought that was ‘soft’! I recall I left shortly after that. They stayed on to talk’. The Manager was in her Chief Executive’s office when he finally rang the Provider’s Chief Executive to tell him of his decision to end the contract. The formalities of the wind-up process were then agreed.

The Manager often reflected on this stage of the interorganisational relationships that ended

I have thought about my emotions in these final stages of the three relationships – and troubled times in others. Upsetting others makes one feel intimidating and intimidated. It is hard, it is tough. I don’t really like feeling this. It is a strange sense of authority - maybe it is power - mixed with some sorrow. It is a big high and then straight away, a low. Then there is some sense of chasm – now I have to rebuild quickly. I was so tired at the end of the food and environmental services decision. The wind-up process was unpleasant. They sent in a young aggressive fellow who seemed to want to target me. I did not need this and so I handed it to others to wind up.

4.9.2 Developing the Service Agreement

There was no formal specification for the early human resources services. The Provider was awarded the contract for three years in 1995. The Provider located three Advisers in the Hospital. Their role was to develop Hospital line managers’ skills to
enable Human Resources responsibilities to be devolved. The Provider’s employees were a Senior Human Resources Adviser, an Occupational Health and Services Adviser, a Workcover Adviser. In addition there was an Administrative Officer. As line managers required help with Human Resources issues, they made contact with the Provider’s site representatives. Over time the capabilities of line managers developed, particularly those managers who actively engaged with Human Resources matters.

The Manager of Finance advised the Manager in June 1998 that the Provider’s Agreement was due to expire and would require renewal. The Manager developed a new and more detailed services contract that the provided was happy to sign.

A Human Resources Services Audit survey conducted by the Provider in 2000 showed that some managers had no contact with the Provider while others contacted the Provider on specific human resources issues such as Occupational Health and Services. There were indications that some of the Provider’s employees formed stronger connections with Hospital managers. These connections strengthened the relationship between the Hospital and the Provider.

4.9.3 Management of the Interorganisational Relationship

The Manager was actively involved with the provider and kept the Chief Executive informed about any issues or contractual matters that she decided needed his attention. Otherwise she acted quite independently on operational matters. Additional fee-for-service arrangements were sometimes agreed between the Chief Executive and the Provider independently and this made it difficult for the Manager to always know what was happening. The Manager found this frustrating.

The Manager was aware of the special relationship between the Provider and the Chief Executive. As a newcomer to the Executive of the Hospital the Manager soon identified a sub-culture existed in the relationship between the Provider and her Chief Executive. She decided that she needed to respect this. The Manager had to be sure her own leadership would be supported at the Executive level before making any changes with the Provider’s services.
She began to the metaphor of ‘mateship’ to describe her perception of this special kind of relationship. This was a particular interorganisational relationship that she would need to respect. The Human Resources interorganisational relationship was one of much longer duration than her own with the Chief Executive. One of the Provider partners had worked very closely with the Chief executive for a long time and had a special bond. The Chief Executive had helped him with his business. However, this connection often meant that he tried to ‘distance’ himself in some decision-making situations by permitting the Manager to make the decisions.

The Manager recalled when she first started at the Hospital and when she began to sense the relationship between the provider and the Chief executive. It was after she had an impromptu visit from one of the Provider’s partners:

This tall man just arrived and walked into my office like he owned it. I was in the middle of something else. He was extremely comfortable and he just took over the space. He was very assertive, almost aggressively so. I remember thinking that it was like he had come to tell me how it was here and that all was well and this is how it would work. He seemed to be determined for me to know that he had a special connection with the Hospital and that I would not need to do much. He had everything in hand. Things were working well. There was nothing I needed to do and if there was he would sort it out with the Chief Executive. It was so over the top. I had no other role but to listen. It was amazing.

After he left I wondered what on earth that was all about! He was intimidating, dominating and disrespectful. I became determined not to be stepped on, I suppose. What an introduction I thought!

As she became aware of the Provider’s connections the Manager decided that for her first few months at the Hospital she would just monitor the services and respond to problems or queries from the line managers. The Provider’s Senior Adviser was included in the Manager’s monthly divisional meetings. The Manager not only managed the Human Resources interorganisational relationship but she also accessed the Human Resources services as she needed to support her own operations.

The focus of the Provider’s services developed to service Hospital managers’ needs. In this way the Human Resources services were framed around the needs of key stakeholder clients. As a result its services adapted over time as different and
emerging demands were made. It came to be expected that it would adapt in this way and not remain static. Table 4-10 summarises some of the key events that the Manager recalled about her management of this interorganisational relationship.

Table 4-10 Event Timeline: Human Resources Interorganisational Relationship

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1998</td>
<td>New Manager arrives.</td>
</tr>
<tr>
<td>Monthly</td>
<td>Joint Review Meetings.</td>
</tr>
<tr>
<td>June 1998</td>
<td>Incumbent Provider’s manager leaves.</td>
</tr>
<tr>
<td>September 1998</td>
<td>Hospital purchases adjacent hospital. The Provider assumes responsibilities to support across the extended campus. Chief Executive appoints the Provider to facilitate the integration of new hospital and the Hospital through a restructure. New hospital staff transferred to Hospital payroll.</td>
</tr>
<tr>
<td>December 1998</td>
<td>The Provider advises Chief Executive on redundancies and restructure. The Provider’s Adviser begins assisting the Hospital with operation of Food and Environmental Services contracts.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>The Provider assists Hospital managers and staff as required. At a monthly Joint Review Meeting the Manager seeks input to development of human resources performance indicators to enable monitoring of the Provider’s services in terms of human resources outcomes. The Provider tables some generic indicators. These are noted. No application or analysis as to suitability for the Hospital or the relationship. The Manager receives copy of a statement of intent to deliver Human Resources services signed between the Provider and the Hospital and due to expire. The Manager of Finance asks the Manager to renew with the Provider. The Manager conducts consultative review of the service contract. Results mixed.</td>
</tr>
<tr>
<td>June 1999</td>
<td>Two year extension signed.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Monthly meetings.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Human Resources Function Team activities.</td>
</tr>
<tr>
<td>June 2001</td>
<td>Chief Executive appoints previous Provider partner to deliver 360-performance management tool into the Hospital. Incumbent provider has no role in the performance management. The Manager conducts consultative review of the Human Resources contract.</td>
</tr>
<tr>
<td>September 2001</td>
<td>The Manager begins to establish new relationship with ex Provider partner through the 360 performance management program.</td>
</tr>
<tr>
<td>December 2001</td>
<td>Longest standing Provider site employee resigns from the Hospital and the Provider because of irreconcilable difference. The Provider disputes level of replacement required and puts in temporary staff.</td>
</tr>
<tr>
<td>February 2002</td>
<td>The Manager appoints internal consultant to work on the “Return to in house” project. Advisers direct role in strategic operations with those departments’ declines.</td>
</tr>
<tr>
<td>September 2002</td>
<td>The Manager appoints new Hospitality Services Manager. The Provider’s Adviser establishes new daily working relationship with this person. The Manager refocuses on strategic issues relating to the contract and performance. The Manager continues to build relationship with ex Provider partner</td>
</tr>
</tbody>
</table>
Informal arrangements and understandings between all the stakeholders developed. There was no central leadership of the Hospital’s Human Resources function, rather it was a shared leadership by cost centre managers and defined by local needs. The Manager reflected:

In my early months at the Hospital I just monitored the arrangement. It seemed to happen anyway. I was supportive of the devolution of Human Resources to line managers and there were plenty of them, so it seemed to run itself. It was twelve months later that I decided to assume a more active overall leadership for Human Resources.

This approach led to the view that the relationship between the Hospital and the Provider ‘just happened’. Unlike the Pathology relationship for which this expression was also used, with the Human Resources interorganisational relationship the expression had a different meaning. With this service it described the view that the

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb. 2002</td>
<td>The Manager advises the Provider that it has decided to do a market test for Human Resources Services. The Manager confides to the Provider’s site manager that she would want him to stay on at the Hospital if the contract was not renewed.</td>
</tr>
<tr>
<td>April 2002</td>
<td>The Hospital officially advises that the current contract will end. Providers invited to submit proposals for new Human Resources services based on a specification and vision defined by the Hospital. Provider fails to submit a proposal in the time lines. Providers are invited to present their proposals to the Chief Executive and the Manager. Incumbent provider attends without documentation and effectively throws the opportunity. The Hospital advises the Provider that the current contract will end. Discussions commence on winding up the contract.</td>
</tr>
<tr>
<td>12 June 2002</td>
<td>The Provider relationship ends.</td>
</tr>
</tbody>
</table>
relationship was adaptive. Each manager developed his or her own special relationship with the provider’s advisers based around their unique needs. The Advisers understood that this was the nature of their service responsibility. Over time they developed close relationships with individual Hospital managers such that they came to identify themselves as ‘members’ of the Hospital. The Provider’s head office people did not understand this well and there were occasions when this upset their site personnel. The Manager recalled one particular occasion:

I recommended that the Provider be paid a significant bonus after we had a really good year with our human resources. We won several awards and the provider’s site employees and our managers had really worked very well together. I had anticipated that some recognition might be passed on by the Provider’s head office to the site employees. However nothing happened. The site Senior Adviser heard about the bonus and became aware that they had not also been acknowledged. He was furious and disappointed. I recall he made his views known to his employer. It somehow left a bad taste. I had hoped that some benefit would flow to the site employees. I had to win support from my Chief Executive for the bonus – he told me it was not something he had done before. We felt we could not pay the employees direct because they were not our employees. So we paid their employer but he decided not to give anything back to them. It was sad and created some bitterness. On reflection it would have been best perhaps to have not done anything – at least not involving money.

In 2000 the Manager undertook a stakeholder review of the Provider’s services and reported the findings to the Hospital Executive. Feedback was also given to the Provider. The feedback results were similar to the earlier survey and suggested that the Provider’s services were not used by all cost centre managers. The Manager represented this to the other Executive members as a possible indication of the growing capability of the Hospital managers.

Contrastingly, concern was expressed by some that the Provider could take more initiative in its delivery of support. For example, senior nurses were not happy that the Provider did little to alert the Hospital to the impending impact of the nursing shortage that hit the Hospital hard in 2000/2001. This highlighted limitations in the Provider’s provision of strategic Human Resources advice.
At the time of the first contract renewal in 2000 there was discussion at Executive about whether to continue with the outsourced arrangement. The Chief Executive and the Manager remained committed to the devolved Human Resources approach. Cost comparisons were made with a return to in-house but these were not accepted. The Manager and the Chief Executive agreed to support another term with the Provider. On this occasion more detail was requested from the Provider and in addition the Manager prepared a formal contract of services. The Provider signed for a further two-year period.

To strengthen and co-ordinate the Human Resources function, the Manager established a Human Resources Function Team. This was a group of the Hospital line managers, and the Provider’s representatives, who met monthly to discuss human resources issues and develop initiatives. It became very successful and widely recognised in the Hospital as a contributor to human resources policy and practice. The Human Resources provider came to rely heavily on the group and the Human Resources Function Team came to represent the success of the devolved human resources model.

This devolved model of human resources is shown in the following Figure 4-1. It represents the way that line managers and employees interacted with the external provider’s services in a supportive, learning process. The nature of this process contributed to the emergence of close working relationships and high levels of trust between the provider’s advisers and Hospital employees.
Towards the end of the contracted period the Chief Executive engaged another external consultant to introduce a new performance management program into the Hospital. The Manager sensed awkwardness in this because the external consultant was the old human resources provider partner who had split and re-established contact with the Hospital. Comparisons between the two service providers began to emerge.

Over time the Provider’s service delivery had become routine and transactional. There were some in the Hospital looking for more initiative and strategic advice. The Manager began to compare the declining quality of the Provider’s services with the new business being developed by the old partner. In the lead up to the contract expiry date the Manager advised the Provider that there would be a competitive tender for the Hospital contract. The Provider did not tender and the Hospital engaged the original partner’s new company.
Interviews with the Nurse Managers showed that their involvement with the Provider was very much related to contact when help was needed with specific issues. The Provider’s site manager often illustrated the learning responsibilities in the devolved model by referring to examples of managers seeking help and being able to act independently when subsequent similar issues arose:

I'm here five days a week full-time and I don't have a problem with the dichotomy. Provider versus the Hospital is not a problem. I can be part of the Hospital on a daily basis and I can work with people whom I consider to be peers and colleagues. I can go out of here and go back to the Provider and talk to people who are also my peers and colleagues, I don't have a problem with it.

The thing that's probably useful for me is nobody in particular gives me too much instruction. What I mean by that is, if I was told to generate $X in money outside the contract if that was part of my KPIs for the service delivery that I must write down the cost and keep them below that figure, I would find it extremely difficult. The reason I would find that difficult is that it's a challenge to your integrity from both angles … people leave me alone to do my job. When I see a need for buying in expert knowledge I'll go and I'll say we need to do this and its going to cost you that, but I don't do it to generate business. I do it because there is a need and likewise with the company I work with, if they put those sorts of drivers on me, and my behaviour, then I probably wouldn't be able to operate.

And the Adviser commented further:

I've got XXX with me - I'm not sixty-seven people … I encounter very small problems from a provider point of view because I'm only managing myself and one other person. If I was here managing sixty-seven people from the Hospital on another company's behalf, I don’t think I would be here quite frankly because I would then be expected to work within a budget and make a profit. You guys would keep me within tight parameters and like I say, as soon as you start to cut corners it affects morale. That feeds on itself, you get more problems.

4.9.4 Billing

The contract was a fixed price one and each month invoices were submitted and paid. There were additional invoices for legal expenses and from time to time the provider was engaged for additional work on a fee-for-service basis.
Towards the end of the interorganisational relationship there were additional billings for services that the Hospital had once taken for granted as part of the services. Emotions developed over these billings but despite her efforts to discuss this emerging issue and the Hospital’s surprise and disappointment the provider was disinterested to engage in discussion. Manager drew her Chief Executive’s attention to the matter but still nothing changed.

**4.9.5 Monitoring**

Monthly Joint Review meetings were held with the Provider and these were the main governance mechanism to monitor progress of the Human Resources contract service delivery. Representatives of both Hospital management and the Provider’s site management attended this meeting. It was rare that the Provider’s head office personnel attended and because of this the meeting became ineffective over time. The close professional working relationship of Hospital managers and the provider’s site employees seemed to create little need to elevate discussions to higher levels for discussion. The Hospital employees were relatively satisfied knowing that they could access whatever they wanted from the site Adviser. The Manager, however, was mildly frustrated by the lack of strategic leadership but the Monthly Joint Review Committee meeting was not the appropriate forum for such discussions. The meeting lapsed in the latter years as the Human Resources Function Team replaced it.

The Manager recalled:

> I remember that the Provider had a very comfortable relationship with the Chief Executive and the Hospital. The partners rarely came to a Monthly Joint Review Meeting. As I had decided to let things go quietly for a while, and I was busy getting to understand the food and environmental services businesses in any case, I just let the human resources happen.

> In fact it was not until a comment by our Director of Nursing along the lines, ‘well Human Resources is your area so it’s up to you how you want to approach it’, that I began to think more confidently about assuming leadership of the function. I recall sensing that she had given me her support and ‘permission’ to take a more prominent role. I knew she was also aware of the special connection the provider had with the Chief Executive. So it was in fact after this that I began to take a more
active steering role. Nurse Managers seemed also to appreciate this leadership because I began, through the Human Resources Function Team that I established shortly after, to enable them to have some organisation – wide role.

The Human Resources Function Team worked as an informal but effective governance mechanism as well as a very productive working party. The group achieved more for the development of the Human Resources function at the Hospital than the Provider’s advisers and line managers alone did. With the Manager as Chair initially the group assumed some leadership of operational Human Resources in the Hospital. Through a membership of key Hospital line managers it discussed issues and made things happen for the Hospital as a whole. The Human Resources Function Team built a reputation as a key standing committee in the Hospital and it was acknowledged by external Hospital accreditation auditors. The Provider was pleased to be associated with this success and they came to accept that the Human Resources Function Team was integral to its business model. The Human Resources Function Team had come to symbolise the knowledge transfer approach. In fact when the first contract renewal occurred the provider insisted on having the structure referred to in the new contract.

The success of the Human Resources Function Team demonstrated the knowledge and capability that had been built within the Hospital through the workings of the interorganisational relationship. Interestingly, recognising this success and sensing that they had all developed as managers, these same managers, including the Manager, began to express feelings of frustration. They began to want more from the provider. Expressions about ‘doing their business for them’ began to be made. The Manager sensed that perhaps the Provider/Hospital relationship had become ‘of age’. The Provider’s services capability seemed unable to grow further with the Hospital manager’s perceived needs to be further extended.

The Provider reported monthly to the Hospital executive on its activities and there were two staff climate surveys over the research period. The Executive was sensitive about the results of these surveys and reluctant to communicate the results to employees. The Provider, on the other hand, did not appear to feel in any way
responsible for the results and always maintained that their responsibility was only to provide advice.

4.9.6 Summary: Perceptions of Interorganisational Relationship Functioning

In 2000 the Human Resources Function Team achieved some high profile outcomes. The Manager recommended to the Chief Executive that the Provider be given a substantial bonus payment. The Manager recalled the Chief Executive admitted that: ‘This has not been done before’. These were high emotion periods when the interorganisational relationship worked well. There were also sad aspects to the interorganisational relationship, the Manager reflected, such as when the provider’s employees left the Hospital:

A lot was ‘invested’ in these service provider managers - a lot of relationship building goes on. The Provider’s employees often looked to the Hospital with hope they could be employed by us. They did not want to leave the Hospital. There were a number of teary departures. They liked working at the Hospital and came to view it as their place. But, they left because they no longer could relate to the Provider’s Head Office/Central office. It was difficult for us, but I could not do much for these guys.

They (the Provider’s staff) seemed to ‘get caught’ between their own employer and the Hospital. I think the provider’s employees felt more part of the Hospital than their own organisation and this created difficulties. One employee confided that he found himself putting the Hospital's interests above his own organisation. This was particularly stressful if it had financial impacts. I recall that, after the partnership split, the Provider’s site manager was re-orientated to ‘sell more business’ to the Hospital.

This change also coincided with a sudden increase in billing rates on legal and industrial relations services charges. The Provider’s site manager was unaware of this. The Manager discovered this when the charges on invoices increased. The Manager found this disappointing and it led to the inevitable question: what is in and what is not in the contract? ‘It was disappointing because there was no executive level approach from the Provider to discuss this change in approach. I also found it disappointing that I had to hear this officially from the site employees. They felt bad
because they had to admit to something they had been instructed to do against their normal practices,’ the Manager recalled.

The relationship between the Provider and the Chief Executive, and then the split within the Provider created interesting complexities for the Manager. At the operational level she was like any other line manager and made use of the services. At the relationship level she felt that her role and authority was different. She attributed this to how she perceived the mateship at these levels. She felt that she had less authority and that sometimes decisions about engagements were made without her involvement. The Manager recalled these ‘surprises’ as part of the relationship context that she had to accept. She recalled it made her feel ‘separated’ and ‘powerless’ when other managers enquired about what and why certain things happened. The Manager recalled that she did not ‘enjoy’ being placed in this sort of position. There were times when she and the Director of Nursing talked about their experiences and acknowledged how they had to be ‘careful’ about appearing concerned about the way decisions were made.

The relationships that developed between the provider’s employees and line managers were strong. The Manager communicated her perception to her Chief Executive that this helped to make the devolved model of human resources successful. She also felt that her own leadership contributed to its evolution over the years. These ‘ingredients’ were fundamental to its success. The provider partner who went out on his own during the relationship period had observed that there was something unique about the Hospital service. Despite the Provider’s attempt to replicate the model at other sites it did not work as it did at the Hospital. The Manager believed that it was a strong team approach, the Chief Executive’s overt support and her own leadership that contributed to its success. ‘It was really about strong social connections at the working level. We all respected and relied on each other’,” the Manager reflected.

4.10 Chapter Summary

The Manager often reflected on the six interorganisational relationships for which she was responsible. She was always tempted to believe that the human resources relationship ‘worked the best’. However, when she reflected on why she felt like this
it became less clear to her that this was necessarily true. During this research she began to identify that she might be using ‘filters’ in her reflections. These acted like ways of thinking and they could affect the sense she made of her experiences. What were these filters that she could be using? With further reflection she began to identify that there might be factors, or attributes, in her organisational setting, in her professional experience, as well as in herself that could be influencing her sense-making. Michelman (2004, p. 2) noted that, ‘these filters govern which data lands on the active agenda of our consciousness and which gets shuffled off to the mind’s dark corners.’ This realisation helped the Manager to make more sense of her management experience with the interorganisational relationships at the Hospital. It worked for her on two levels. It helped her to begin to understand why she engaged in certain management routines at the time, and also why she perceived that the management of interorganisational relationships was so hard.

The next chapter presents the researcher’s reflexive interpretations about the Manager’s interorganisational relationship management.
5 THE MANAGEMENT OF INTERORGANISATIONAL RELATIONSHIPS: THE MAIN FINDINGS

5.1 Introduction

This chapter presents the key findings of the research. First there is discussion in Section 5.2 about the themes that emerged during the reflexive interpretation process. These themes in turn provide a framework for further reflexive discussion on the narratives in Section 5.3 and, taken together, they respond to each of the research questions. The Chapter ends with a summary in Section 5.4. Where appropriate, links with the literature on interorganisational relationships presented in Chapter 2, are made throughout this chapter.

5.2 Emergence of a Sense-making Framework for Management

The narratives in Chapter 4 reveal that the Manager engaged in a diverse and complex management process to construct six interorganisational relationships at the Hospital. Her enactment of her responsibilities appears erratic and more personal, than prescribed, patterned, or logical. By getting ‘inside’ the collaborative context, this research has revealed that this client’s involvement in service delivery management is not diminished through partnership. In some interorganisational contexts it appeared that the level of client involvement had a powerful influence on interorganisational relationship functioning.

5.2.1 Management Activities

During the writing of her narratives the researcher/Manager took time out to compile a list of management activities that she, and other managers, recalled using in their daily management of the six interorganisational relationships. Each activity described the explicit behaviour (the performative aspect of a routine) of the managers. These management activities are documented in Appendices 1 and 2 and they represent the first layer of interpretation: an interpretation that is largely functional.

During subsequent reflection, the researcher/Manager began to appreciate that these management activities were associated with underlying reasons (the ostensive aspect of the activity). Sometimes these activities derived instantly from the context, as in reflex interaction (Cunliffe 2002) wherein the perceived or observable behaviour
involved acting out of instinct, feeling, or habit. These were actions based on tacit knowing borne of institutionalised routines. Further, there were times when the researcher understood her actions through a reflexive ‘conversation’ within herself. Cunliffe (2002, p. 40) referred to this as an ‘inside-out approach … in which we ourselves are text – in-relation-to-others’. The Manager came to understand these activities as routines that involved not only the explicit behaviours but also structures, or ‘programmed’, institutionalised rationales, for behaving (Weick 1993; Feldman & Pentland 2003). Hence, the Manager began to understand that her management processes often derived, unconsciously, from these institutionalised ways of doing things.

5.2.2 Emotions

With continuing periods of reflection about her interorganisational relationship management, and the experiences of other managers, the researcher/Manager identified that some routines were associated with different emotions (Hochschild 1983; Goleman 1995, 1998; Diefendorff & Gosserand 2003; Scott-Ladd & Chan 2004). Table 5-1 describes some of the emotions that emerged through this reflective/reflexive process.

The researcher was drawn to think most about these routines embodied with deep emotion – emotion derived from frustration, a desire to control an outcome, or a lack of trust, perhaps? The language used in the phrase ‘doing their business for them’, embodied a knowledge structure, or cognitive schema, and a physical response, or emotion. This phrase may have expressed frustration (‘I can’t wait for you any more. I will do this for myself, even though I think you should be doing this’). There were other reflections that expressed the Manager’s orientation (‘Here, I will do this because I know how to and I can show you’). The Manager felt, ‘caught’ in his network of relationships and she reflected that, ‘I felt small!’ These emotions suggest that the Manager felt marginalised at times and she developed a sense that the Human Resources provider had special relationship with the Chief Executive such that she would be have to be ‘careful’. There were also expressions that suggest the emotions of power and control (‘by doing this I know that I will save money’, or, ‘if I develop the contract then it will not be written so much in their favour’).
The Manager reflected that the activity of meetings had several meanings. She came to understand that there were times when she used meetings for the purposes of control, other times for social connection, for communication, negotiation, performance, or for ‘getting things done’. Embedded within these simple statements was the world in which the Manager was making sense of her lived experience. In the early stages of reflection the researcher struggled with these emotions and with their multiple purposes and meanings, and also with the routines and contextual influences associated with them in the different interorganisational relationships (Rafaeli & Sutton 1989; Dutton et al. 2001; Diefendorff & Richard 2003). With each revisit to this task of trying to understand why she acted the way she did, the Manager noticed that new understandings were constructed. In time the researcher/Manager began to sense personal cognitive structures that were more challenging for her to consider. She sensed that she possessed personal ‘predispositions’ and that these might strengthen the emotional association between certain routines and actions that she selected.

Table 5-1  Managers’ Feelings associated with Management Routines

<table>
<thead>
<tr>
<th>Managers’ feelings associated with management routines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frustration</td>
</tr>
<tr>
<td>Dis-empowerment; responsibility without accountability; lack of control</td>
</tr>
<tr>
<td>Congruence – acceptable symmetry between the provider’s services and the Hospital’s requirements</td>
</tr>
<tr>
<td>Marginalisation; feeling ‘left out’</td>
</tr>
<tr>
<td>Uncertainty about leadership/role/accountabilities</td>
</tr>
<tr>
<td>Rewarded positively motivated</td>
</tr>
<tr>
<td>Confusion about who was responsible</td>
</tr>
<tr>
<td>Nonchalance and ambivalence; resigned acceptance of a situation</td>
</tr>
<tr>
<td>Impatience</td>
</tr>
<tr>
<td>Pressure to meet perceived expectations of role and accountabilities</td>
</tr>
<tr>
<td>Equity concerns about provider profit taking vis a vis Hospital cost pressures</td>
</tr>
<tr>
<td>Trust</td>
</tr>
<tr>
<td>Enthusiasm</td>
</tr>
</tbody>
</table>

Source: Developed for this research
5.2.3 Contextual Interpretive Frames

Themes began to develop during this reflexive process. It emerged for the Manager, that there were cues (Dutton et al. 2001), or contextual influences, in each of the interorganisational relationship context, that stimulated her conscious sense-making (Chikudate 1999b; Dutton et al. 2001). Further, the emotion appeared to derive from ‘within’ the Manager’s ‘self’ (Compeau 1994; Walsh 1995). The combination of contextual influences and the Manager’s own dispositional attributes led the researcher to develop the notion of contextual interpretive frames. Contextual interpretive frames refer to an association between contextual influences, emotion and their enactment through such activities as meetings, monitoring behaviours, negotiations and report writing.

There were five contextual interpretive frames identified by the researcher/Manager identified during these reflective/reflexive periods. As the Table 5.2 shows there was a contextual interpretive frame that related to a perception of ‘acceptable symmetry’ or sense of ‘fit’, between the interorganisational relationships partners (Senge 1990; Forrest 1992; Dyer 1997; Dyer & Singh 1998; Dyer & Nobeoka 2000; Piderit 2000; Useem & Harder 2000; Kale, Singh and Perlmutter 2000; Li et al. 2002).

A second contextual interpretive frame was about ‘relational ties’, or, social connectedness, between interorganisational relationship members (Van de Ven 1976; Barringer & Harrison 2000; Hutt et al. 2000; Hitt et al. 2002; Johnson et al. 2002).

‘Trust’, and its contribution to governance and legitimate behaviours was a third contextual interpretive frame (Das & Teng 1998b; Das & Teng 2000), as was a fourth that has been called, ‘managerial cognition’, which was enacted through choice of operational routines (Goolsby & Whitlow 2003; Useem & Harder 2000).

A fifth contextual interpretive frame has been called ‘personal orientation’ because it relates to the Manager’s disposition to encourage other actors to her view of how ‘reality’ will be constructed (Hubbard 1997; Schell 1991; Wright 2000).
Table 5-2  Contextual Interpretive Frames Affecting Sense-making

<table>
<thead>
<tr>
<th>Contextual Interpretive Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acceptable Symmetry (congruence)</td>
</tr>
<tr>
<td>Perceiving the compatibility between interorganisational relationship partners and the acceptability and legitimacy of interactions. Managing change and building absorptive capacity into the relationship.</td>
</tr>
<tr>
<td>2. Relational Ties (connectedness)</td>
</tr>
<tr>
<td>Perceiving constructive relations, and positive emotions in social interactions with external provider members, Hospital members. Vertical and horizontal web of connections. Responsive dynamic stakeholder expectations and satisfaction.</td>
</tr>
<tr>
<td>3. Trust (governance)</td>
</tr>
<tr>
<td>Feeling ‘safe’ and ‘protected’ in the interaction and pursuit of mutually beneficial objectives. Reciprocity.</td>
</tr>
<tr>
<td>4. Managerial Cognition (operational routines)</td>
</tr>
<tr>
<td>Implementing interactions and decisions to accomplish service delivery within the interorganisational relationship context, such as, monitoring, authorising resources. Codifying learning into procedures to use for future alliance success; overcome obstacles in operations.</td>
</tr>
<tr>
<td>5. Personal Orientation (my view)</td>
</tr>
<tr>
<td>Communicating and adopting approaches and objectives that affect the relationship, such as, not-for-profit and for-profit; collaboration and control; role and responsibilities; agency.</td>
</tr>
</tbody>
</table>

Source: Developed for this research

In the initial stages of functionalist interpretation the Manager’s management routines were simply listed. However, these were later grouped using these contextual interpretive frames (Appendix 2). Existing management typologies were considered, however, since the emphasis of this study was not to validate these existing classifications the researcher instead used the contextual interpretive frames to construct a ‘profile’ of the Manager’s involvement, for each of the interorganisational relationships.

5.2.4 Dispositional Sense-making Filters

There were times when new understandings emerged that concerned the researcher/Manager. Table 5-3 identifies some of the affective events that influenced the Manager’s as sense-making.
<table>
<thead>
<tr>
<th>Filter</th>
<th>Affective event</th>
<th>Sense-making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptable symmetry</td>
<td>‘doing their business for them’. (Dissertation p.177)</td>
<td>Why are we doing these things for ourselves? This is the service we want from them. Why are we doing this?</td>
</tr>
<tr>
<td>Trust</td>
<td>A departing provider employee advises the Manager that his organisation made a conscious decision not to respond to the Hospital’s request for an integration plan after a hospital acquisition. (Dissertation p. 141) Provider manager suggests that the Manager does not trust him to run the business. (Dissertation p. 142 ) ‘Whenever we talked about contractual matters - and not only with the pharmacy provider – interactions seemed to become harder. Conversations were tense and more formal’. (Dissertation p. 134)</td>
<td>How did this happen? Were there some discussions at a higher level that I was unaware of? This confirms my concern about our levels of trust. What do I do now? I think of myself as trusting others. How is it that this person sees my participation as a sign that I don’t trust him? Do I trust them? Maybe I don’t after all! Why is this so? Our interaction to date suggests that there is too much risk to the Hospital if I let them make all the staffing decisions. Why is that that we seem to become so guarded when we even try to articulate what we want? We seem to have trouble accepting that the provider needs to make a profit. Talking about money is hard. It’s because we didn’t talk about this at the beginning that we now have this problem. How do we come to agreement?</td>
</tr>
<tr>
<td>Personal orientation</td>
<td>‘I remember thinking that it was like he had come to tell me how it was here and that all was well and this is how it would work’. (Visit by Human Resources provider partner) (Dissertation p. 169)</td>
<td>Why do I feel that I am being talked at? Why does this person believe they can tell me what they will do when it is my position?</td>
</tr>
<tr>
<td>Acceptable symmetry</td>
<td>“I had a distinct impression that this was not something that the provider wanted to do”. (The Pathology Provider seemed reluctant to engage in the discussions about standards of services) (Dissertation p. 123)</td>
<td>Surely it is obvious that this is a good thing to do. Why does this organisation not see it the same way?</td>
</tr>
<tr>
<td>Trust</td>
<td>These are my employees so I will maintain my responsibility for them. (Dissertation p. 143)</td>
<td>They are my employees. They are my responsibility. How can I give this to another organisation? Am I at risk if I ignore their needs and therefore my own? Hw is this supposed to be managed?</td>
</tr>
<tr>
<td>The provider needs to make a profit. (Dissertation pp. 144-146)</td>
<td>This means I am paying more than I would otherwise pay for something I could do for myself. Why do I want to do this? How do I learn to like this?</td>
<td></td>
</tr>
<tr>
<td>Personal orientation</td>
<td>‘Sometimes I used to think that this informality in the decisions process seemed to suit the providers. He could have a conversation in his office to sort things out. And really some of the issues should never have arisen. It should have been something that I could have sorted out’. (Dissertation p. 134)</td>
<td>Maybe I was too controlling on occasions and my perception was that his informality and relaxed approach made it harder for me to manage. I maybe should adopt his approach. He is probably right. How can I adopt this more relaxed approach and still be knowledgeable about what is happening with the provider’s services? Do I just wait to hear about complaints and then do something?</td>
</tr>
<tr>
<td>Personal orientation</td>
<td>‘just happens … where is the leadership?’ (Dissertation p. 124)</td>
<td>Yes. It is legitimate for me to take leadership and my professional colleague will support me in this.</td>
</tr>
<tr>
<td>Personal orientation</td>
<td>‘Well Human Resources is your area so it’s up to you how you want to approach it’ (Dissertation p. 176)</td>
<td></td>
</tr>
<tr>
<td>Personal orientation</td>
<td>‘Their corporate machine was good at this sort of thing … it was good working with</td>
<td>This is right. I can respond to this. I know what I am doing. We can discuss this</td>
</tr>
</tbody>
</table>
The event timelines included in the Manager’s narratives for the peripheral non-clinical support services identify some of the occasions sense-making recalled by the Manager. New understandings emerged (for the Manager) from these events that sometimes revealed for the Manager attributes about herself and her way of ‘sensing’ her context. The researcher was ‘struck’ by a realisation that there were ‘personal influences’ that appeared to create management challenges for her, in her role as the Manager. These personal influences were like the ‘affective events’ referred to by Diefendorff & Gosserand (2003). These affective events impacted the managers’ emotions, feelings and actions. While they were neither anticipated, nor unanticipated, affective events did violate expectations and institutionalised ways of thinking.

The researcher/Manager reflected on these affective events and perceived that her sense-making may have been due to ‘filters’ that were part of her framing; part of her ‘self’. The researcher recognised that there were cues, or sometimes patterns of events, within the interorganisational relationships contexts, that ‘struck’ the Manager. When this occurred the Manager experienced ‘heightened’ emotion that signalled a ‘crucial experience’ in terms of her understanding. Such events sharpened her awareness that new understanding was appropriate and necessary to make sense of her activity and to reformulate her behaviours. It was through this world of filters that she made sense of her collaborative interorganisational relationship context.

Multiple interpretations about the routines in which she engaged, continued to confound the researcher/Manager. Having become sensitised to the possible differences in interpretations within her ‘self’, it began to further emerge that she might be sensing cues in her world through lenses, or filters. These lenses predisposed her to certain appraisals and sense-making, and as well they contributed to the construction of her world view (Walsh 1995). Some of the contextual interpretive frames that had been earlier used to help her understand her management activities.
now became tacit structures that were re-conceptualised as *dispositional sense-making filters*.

Dispositional sense-making filters, thus, emerged in association with critical experiences, or ‘affective events’. They influenced her diagnoses of contextual cues and her decision making about what she would do (Ashforth & Kreiner 1998; Dutton et al. 2001). The researcher/Manager moved backwards and forwards in her thinking about her emotions, between her routines and the events that stimulated the behaviours, as well as her perception of relationships with other managers, the providers and her Chief Executive. Through this recursive interpretative process she made sense of how she managed her interorganisational relationships.

With continued reflection, the researcher/Manager came to sense that at least three of the contextual interpretive frames were crucial dispositional sense-making filters. The Manager associated these filters with high levels of emotion and a sense of stability and consistency in her interpretation and response to contextual cues. These are summarised in Table 5-4. Dispositional sense-making filters could be associated with more than one of the contextual interpretive frames contributing to the notion that these frames were multi layered constructs. The Manager also developed a sense that these dispositional sense-making filters could be associated with more ‘risky’ constructions, such as disagreements for the Manager, the interorganisational relationship and the Hospital.

**Table 5-4 Dispositional Sense-making Filters**

<table>
<thead>
<tr>
<th>Acceptable Symmetry (congruence)</th>
<th>Congruence, compatibility, ‘fit’, legitimacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust (governance)</td>
<td>Belief in and vulnerability to the other. Monitoring and governance-related activity as assurance of relationship ‘safety’</td>
</tr>
<tr>
<td>Personal Orientation (my view)</td>
<td>Reflecting the Manager’s personal view, derived from role identity, frames; the attributes of ‘Self’, for example, guilt.</td>
</tr>
</tbody>
</table>

*Source: Developed for this research*
Dispositional sense-making filters represented the Manager’s ‘self’ in a personal, embodied, context which, in combination with the external context, defined the constructed reality of her interactions with other members of the interorganisational relationships.

Recognition of these emotional influences in managers’ sense-making raises issues about how interorganisational relationships can be managed for effective functioning. For instance, a traditional understanding is that managers make decisions using a “consequentialist perspective” (Loewenstein, Weber, Hsee & Welch 2001). An emotion-oriented approach, recalling Simon’s (1983) concept of satisficing’ decision making processes, suggests that the notion of linear, objective or ‘rational’ decision making is unrealistic. In this research, managers’ decision making in the collaborative, participative context, is less than rational and heavily influenced by personal attributes of the manager. A senior manager’s personal view of organisational ‘reality’ may not always be ‘aligned’ with that of the executive manager. Other managers who engage in the daily, coalface, construction of interorganisational relationships, do so while constructing a different ‘reality’ to that constructed by their senior managers. The later may be remote from the workplace where implementation issues, rather than strategic ones, are omni-present. Interactions within the interorganisational relationship contribute to a different reality-construction context. The challenge then is to integrate these macro and micro ‘realities’. Diversity within interorganisational relationships may be desirable if effective interaction between all stakeholder levels within interorganisational relationships, and between these members and their host organisations, can be achieved.

Related to this is a second issue concerned with the distinctiveness of vertical, as well as horizontal, relationships (social networks) between decision makers and those managers charged with implementing interorganisational relationships. Researchers have explored senior management teams and their relationships with others involved in joint ventures, for example, and found strong positive performance-related benefits when vertical relationships are healthy and supportive. The perceived quality of vertical social interactions was referred to in the Manager’s narratives. Her reflections suggest that these vertical relationships were sometimes cues, or affective
events, that stimulated her sense-making about her management of interorganisational relationships at the Hospital.

Further to these two issues, it appears that organisations may also be vulnerable to risk when emotions that inform management processes, are overly personal, derive from a power-imbalances, are intransient or non-adaptive. The reflections in Table 5-4 suggest that the Manager experienced both anticipated and unanticipated emotions. These observations are also consistent with other researchers’ findings (Weick 1993; Bechara, Damasio, Trnel & Damasio 1997; Lo & Repin 2001; Scott-Ladd & Chan 2004) and the observations that intuitive decision-making involves more diversity and creativity but conversely, extreme emotions lead to bounded rationality as they cloud the actor’s ‘judgements’ (Kaufman 1999). Researchers of emotional intelligence (Goleman 1995, 1998; Mayer & Salovey 1997; Scott-Ladd & Chan 2004) suggest that actors who understand their own emotions can more accurately identify their responses and change, and also better assimilate information, make judgements and problem solve.

5.2.5 Summary

Explicit activities embody an implicit structure and have been referred to as management routines (Hannan & Freeman 1983; Feldman & Pentland 2003). This section has considered the contextual sense-making influences that affected how the Manager and others made sense of, and enacted, collaborative management processes. Exploring the association of routines and emotions has highlighted the significance of emotion and given rise to the concepts of contextual interpretive frames and dispositional sense-making filters which have established the significance of ‘self’ within the context of interorganisational relationship management. The embodiment of activity with emotion at the personal level serves to query the notion of institutionalised purpose, or structure, in ‘taken-for granted activity’. The influence of ‘self’ in management processes and organisation construction helps us to understand why constructing and sustaining interorganisational relationships can be variable and difficult.
The proposition that contextual sense-making frames and dispositional sense-making filters strongly influence how managers make decisions, and, in turn, how they affect interorganisational relationships functioning, is a significant contribution to understanding how interorganisational relationships work. Feelings and emotions emerged to play a defining role. They were found to enrich behaviours and to have positive and negative impacts on perceptions of interorganisational relationship functioning. Negative feelings were often associated with repetitive behaviours and increased management involvement. Positive feelings were often associated with relationship forming and improved interorganisational relationship functioning. These findings extend the research about relationship building.

Feelings emerge from the interactions of interorganisational relationship members. These interactions represent iterative progress towards an effective, functioning interorganisational relationship. In this regard the interorganisational relationship management process is also an iterative, change process directed to the construction of interorganisational relationship functioning. Continued iteration transforms the interorganisational relationship setting. Positive feelings represent the client managers’ perceptions that the interorganisational relationship is meeting their service objectives.

Managers’ comments about ‘loss of control’ and operations ‘just happening’ are consistent with the reported findings of a survey by Linder et al. (2001, 2002) that the ‘rules’ about interorganisational relationships are changing. The findings in the current research about a perceived lack of leadership control may reflect inadequate adjustment by the client to the change inherent in shared control and collaborative management (Das & Teng 1998b). This research about the client’s sense-making processes in managing, and constructing, interorganisational relationships contrasts with previously cited research that explores single contextual factor impacts on interorganisational relationship functioning. Much of the previously cited research has tended to focus on functional investigations of interorganisational relationships. The interorganisational relationship context and the interpretive perspective taken in this research, contribute to elucidating the meaning of ‘interorganisational relationship’ from the client perspective. As such this research extends existing investigations of the interorganisational relationship phenomenon.
In the next section, the researcher adopts the contextual interpretive frames and the dispositional sense-making filters to provide a structure for further discussion of the Manager’s sense-making about her interorganisational relationship management. While this approach provides a framework for the discussion, it is emphasised that each of the parts of the framework is interdependent. This means that the Manager’s sense-making about an ‘event’, or a crucial experience, in one interorganisational relationship context may have influenced her sense-making in another. Over the time the Manager created new knowledge from her experiences in one context and ‘carried’ this with her into another, subsequent, context. All six interorganisational relationships are considered in the discussion that follows so that, where appropriate, comparisons and contrasts, are reflected upon.

5.3  Framework for Reflexive Interpretation

Table 5-5 represents a framework for reflexive interpretation, constructed from the contextual interpretive frames, dispositional sense-making filters and selected significant cues identified by the Manager.

### Table 5-5  Manager’s Sense-making: Framework for Reflexive Interpretation

<table>
<thead>
<tr>
<th>Frames and Filters</th>
<th>Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptable Symmetry (congruence)</td>
<td>Ways of doing things</td>
</tr>
<tr>
<td></td>
<td>Standards</td>
</tr>
<tr>
<td></td>
<td>Relationship structures</td>
</tr>
<tr>
<td></td>
<td>Complementary resources</td>
</tr>
<tr>
<td>Relational Ties (connectedness)</td>
<td>Social accounts</td>
</tr>
<tr>
<td></td>
<td>Feelings</td>
</tr>
<tr>
<td></td>
<td>Purpose</td>
</tr>
<tr>
<td>Trust (governance)</td>
<td>Position control</td>
</tr>
<tr>
<td>Managerial Cognition (operational routines)</td>
<td>Tried and true routines</td>
</tr>
<tr>
<td></td>
<td>Emotions and events</td>
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<tr>
<td>Personal Orientation (my view)</td>
<td>Legitimacy</td>
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<td></td>
<td>Relationships</td>
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<td>Context and Self</td>
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</table>

*Source: Developed for this research*
This framework has provided the structure for further reflexive interpretive discussion about how interorganisational relationships were managed at the Hospital. Each of these contextual interpretive frames/dispositional sense-making filters is considered in turn. The meaning is first established and then each of the cues identified in Table 5-5 is discussed as it has been interpreted to have influenced the Manager’s sense making. A section summary is provided for each of the contextual interpretive frames or dispositional sense-making filters.

5.3.1 Interpretive Frame: Acceptable Symmetry

This section considers the influence of ‘acceptable symmetry’ in the interorganisational relationship management process.

5.3.1.1 Meaning

The concept of ‘acceptable symmetry’ embodies the Manager’s perception about the degree of compatibility, congruence and synergy between organisations in the interorganisational relationship. Some researchers have referred to the concept of ‘fit’ between organisations in business relationships (Dyer 1997; Snyder 1999; Linder et al. 2001). They have illustrated this in terms of partner selection, with emphasis on cultural compatibility, extended into complementarity and mutuality of goals and objectives in the relational process.

The Manager’s perception of ‘acceptable symmetry’ was constructed during her ongoing oversight of the interorganisational relationships. Positive and negative emotions cued this interpretive frame and contributed to her sense-making. In this way she assessed successive events and routines to construct a continuing sense of an appropriate closeness between members of the interorganisational relationships. The concept of ‘acceptable symmetry’ emerged during her reflections as her way to describe the dynamic nature of this closeness which changed, frequently, depending on social interaction over routines and issues that emerged during relationship construction.
The Manager perceived ‘acceptable symmetry’ on multiple levels, as in contrasts between near-core clinical support service providers and peripheral non-clinical support service providers; between the routines of one service provider and another service provider as in activities stimulated by crucial experiences. The sense of this relational compatibility was enacted through management routines that displayed reciprocity for the interorganisational relationship members.

5.3.1.2 Cues and the Manager’s Sense-making

Selected cues within the interorganisational relationship contexts that ‘activated’ this contextual interpretive frame, and stimulated the Manager’s sense-making, are discussed below.

Cue: Ways of doing things
The Manager perceived the Pharmacy Services provider to possess a stronger and stable family orientation. This may have contributed to construction of operating norms and values that were perceived by the Manager, and other managers, to be more compatible with those of the Hospital’s culture. This compatibility was enhanced by ready access for nurse managers and the Manager, to the Provider’s leadership. There was neither a ‘head office’, nor a corporate, mentality. The Provider regularly engaged the Hospital with initiatives to improve pharmacy services for patients and this was valued by the Hospital. These connections were perceived as continuity and symmetry by the Manager and possibly contributed to a stronger sense of integration with the Hospital community.

The Pathology Services and Diagnostic Imaging Services providers, on the other hand, were from larger, corporate organisations where decision-makers were remote and less accessible. Site managers and employees changed frequently. This turnover of site managers broke continuity with local leadership and disconnected interpersonal relationships and social networks. In the context of the Diagnostic Imaging Services provider there was frequent restructuring and career movement. As well, ownership of this provider changed to a Hospital competitor during the research period. This created suspicion and uncertainty that took time to dissipate.
There was also a very strong perception of comfort with the Human Resources provider employees, particularly in the early days. The Manager’s narratives suggest that she perceived the Human Resources Services provider as having a strong involvement with employees at the social and personal level. Employees of the providers sometimes observed to the Manager how they enjoyed working at the Hospital because they were made to ‘feel at home’. These employees came to identify with the Hospital’s culture. Hospital employees embraced them within their own social groups. The Manager recalled how some Provider employees struggled to identify with their own organisation because they felt more like Hospital employees. Some of them experienced problems with this dual identity which led inevitably to their departure from their own employer. The dilemma for these people was that to leave their organisation meant they also had to leave the interorganisational relationship and the Hospital. This was particularly the situation for the Human Resources Services provider’s employees. The level of enculturation achieved with this service provider resulted in some Hospital stakeholders grieving the loss of these people when they left their organisation. From the interorganisational relationship perspective the loss of these people also represented a loss of knowledge and social capital constructed over time within the interorganisational relationship.

In contrast, the Food and Environmental Services Provider’s managers and employees were often newly recruited to both the interorganisational relationship. At one stage the Manager recalled inducting eight new site managers in three years for the one provider. This meant greater involvement in induction activities and discussions to develop a shared understanding to restore and maintain interorganisational relationship functioning. The Manager had a sense that managing this Provider was like ‘managing a parade’ (Browning et al. 1995). However, this also suggests that the Manager may have held a conception of organisation culture as a relatively permanent and managed construction more so than a fluid, dynamic set of structures.

These perceptions about relationship compatibility and congruence are supported by research about identity forming and scripting processes (Pool, Gioia & Gray 1989; Poole et al. 1990; Barley & Tolbert 1997) wherein it has been suggested that continuity and exposure to an organisation’s operating norms may influence cultural alignment (Inkpen & Beamish 1997; Johnson 2000; Li et al. 2002; Child & Yan
2003). However, any suggestion that cultural alignment will not be an ongoing process would be inconsistent with the research about organisation culture. The enculturation of interorganisational relationship managers will be contribute to reducing ‘cultural distance’ and development of the interorganisational relationship subculture. In their respective roles as leaders for their organisations, the interorganisational relationship managers contributed to build subcultures that coalesced around common goals and then enhanced the ‘fit’ between the Hospital and the providers. In the absence of leadership, it is possible that relationship construction could be resisted, leading to the absence of synergistic functioning (Lasker et al. 2001).

The providers’ site managers were involved in dual enculturation processes. The peripheral non-clinical support services managers sometimes expressed feeling caught between their provider’s interests and those of the Hospital’s Manager. The constancy and consistency of her management routines suggest that the Manager was unable to develop a sense that these interorganisational relationships achieved a fortuitous fit with her view of Hospital ‘reality’. Other managers contributed by sense-giving with their assessments and assessments that they could deliver the services themselves. At one stage the Manager observed that everybody thought that they knew something about food and, consequently, they felt able to critique the service. Was this a defensive remark, or one designed to support her sense-making?

The Manager’s narratives about the peripheral non-clinical support services interorganisational relationships reveal an underlying struggle between the service providers and the Manager. This struggle is reflected in the language and metaphors of the Manager’s narratives. For example, the Manager’s accounts refer to ‘tackling’, ‘game playing’, and ‘hitting your head against a brick wall’, as expressions that suggest she was engaged in a battle of different wills. The struggles of other Hospital managers were also borne of their inability to have providers change to the Hospital’s ‘way of doing things’. This expression was a strong reflection of the managers’ intrinsic acceptance of their Hospital’s culture. The routines enacted by them, to encourage, influence, and cajole the providers into meeting their expectations, embodied this intrinsic acceptance.
Managers’ ongoing struggles contributed to routines embodied with emotions such as frustration, mistrust and, ultimately, ambivalence and quiet resignation. The later emotions may ultimately have contributed to their sense-giving to the Manager that the Pathology Services ‘just happened’ and that there was ‘no leadership’. The managers, for a time at least, abandoned their repetitive sense-giving routines to accomplish change. This abandonment suggests they were unable, at this time, to secure the appropriate Hospital leadership to socially reconstruct routines that would enable adaptive change to improve interorganisational relationships functioning. Sense-making remained fragmented (Maitlis 2005) for a time and as a consequence of this ‘abandonment’, the relationship appeared to lack energy. It was not until later, after the research period, that the Pathology Services provider and the Manager recommenced discussions and successfully reconstructed there understandings to achieve some of the service changes wanted by the Hospital.

**Cue: Standards**

The Hospital always prided itself on having a leading and strong reputation for innovation and success. The Manager’s narratives suggest that she sensed the pressures to achieve these high service standards. As she identified with this, it appears that she repeatedly engaged in routines to try to align, and maybe even control, these interorganisational relationships. Reflexive interpretation suggests that she was unable to ‘abandon’ her traditional line management activities in favour of the collaborative approach. She struggled to fully appreciate, and accept, that the service providers of were also commercial businesses. These services were fee-for-service arrangements and the Manager had direct responsibility for their financial management. While profits were at stake for the providers, the Manager persisted in routines to encourage them to make changes that suited her. It is possible that the Manager was so driven to reduce costs, and please her Board and Chief Executive, that she was unable to appreciate that she, too, may have been acting competitively. This was a contextual situation, for the Manager, which differentiated these service providers from the near-core clinical support providers.

Associated with the Hospital’s belief in its self and its strong identity was support for high levels of competency, compliance and conformity to community measures of quality and success. Achieving and maintaining high standards were fundamental to
its identity in the health care field. The Hospital’s managers identified with these socially constructed norms, values, and beliefs (Suchman 1995) and strove to further build and strengthen them. When they did, they were acknowledged as these were accepted organisational values. In the clinical areas, nursing and medical standards, technical expertise and innovation were highly valued and sought after.

Managers displayed a readiness to expect similar high standards in others. In the near-core clinical support providers, this expertise was rarely questioned, compared to the occasions when the peripheral non-clinical services providers were challenged. These culturally based ‘rule systems’ reflect the legitimising process. This is the generalised perception or assumption that the actions of an entity are desirable, proper, or appropriate (Ruef & Scott 1998). Thus, it is possible that the Hospital’s underlying value systems cued the managers’ contextual interpretive frames and their construction of what was ‘acceptable symmetry’.

Some researchers have advocated development of operating norms (Artz & Brush 2000; Kern & Blois 2002) as a way to manage towards compatibility within interorganisational relationships. Others have referred to the process of selection and due diligence (Geringer 1991; Hutt et al. 2000; Hunter & Healy 2002; Goolsby & Whitlow 2003) as activities designed to create ‘fit’. These researchers adopt the concept of cultural synergy as a heuristic for making sense of appropriate partnership in collaborative strategies. The Manager trialled this approach when she consciously established operating norms with a new interorganisational relationship that was not part of this research.

**Cue: Relationship Structures**

The peripheral non-clinical service providers, as a group, were perceived to involve more of the Manager’s attention. In the first instance, these interorganisational relationships were structured or arranged differently. The Hospital purchased services from these providers and the services were, on the whole, provided to support employees of the Hospital. This was in contrast with the more autonomous near-core clinical support services providers whose services were provided direct to patients and where the service contract was technically between the provider and the patient. The Manager perceived that arrangements with the former services providers strengthened
her accountability to ensure the contracted expenditures and service standards were delivered by them. The Manager was also an experienced line manager of peripheral non-clinical support services. As a consequence, she may have perceived that this experience gave her a relevant knowledge base to assist her, or even to justify, her regular ‘intervention’ in the service delivery process. While organisational learning theory might support this interpretation there are findings from studies about prior learning and interorganisational relationships that suggest that the type of previous experience matters (Child & Yan 2003).

These relationship structures may have cued the manager to differentiate the interorganisational relationships. In the near-core clinical support services interorganisational relationships, the Manager sensed them as ‘autonomous’ organisations, engaged for their expertise and fully resourced to deliver services at externally recognised (accredited) quality levels. The Manager understood that, while she was responsible to manage them contractually, she was not accountable for their service outcomes. This sense-making enabled the Manager to establish more trust and, on this level at least, to perceive an ‘acceptable symmetry’. In contrast, she was unable to reach this level of comfort with the Food and Environmental Services interorganisational relationships wherein she sensed that another organisation was managing her employees, and perhaps to a different set of standards. As she not only felt responsible, but also accountable, for the outcomes of these interorganisational relationships, it is possible that the structural arrangements for these services cued her ongoing efforts to control the providers.

**Cue: Complementary Resources**

The attribute of ‘complementarity’ relates to suitability between partners in terms of objectives, assets and capabilities (Geringer 1991; Child & Yan 2003). The Manager’s sense of complementarity may have contributed to construct her perception of ‘acceptable symmetry’ within the interorganisational relationships. As she contrasted the different interorganisational relationships during her reflections, the researcher/Manager constructed the notion of ‘residual competency’. This notion captured her sense of the Hospital’s retained depth of competency, or ‘know how’, in a field after outsourcing services in that field to near-core clinical or peripheral non-clinical, support service providers. The Manager came to enact her routines, and her
level of involvement with the interorganisational relationships providers, in terms of her perception of levels of Hospital residual competencies. For example, when she perceived a low level of Hospital ‘know how’ (that is, low residual competency), the Manager respected the providers’ autonomy in service delivery and ‘withdrew’, enabling the provider to assume accountability. The providers’ own actions in this regard contributed to sense-making that strengthened the Manager’s perception of complementarity and enhanced her assessment of ‘acceptable symmetry’.

The Manager’s reflections also led her to develop the notion of ‘management intensity’. This represented her perception of her level of involvement in various management routines within the interorganisational relationships. During her reflections she came to associate some interorganisational relationships with higher management intensity than others. She came to appreciate that some ‘events’ triggered higher levels of her involvement, such as developing service agreements, responding to complaints, negotiating budgets and funding, trying to agree a change to service delivery from a service provider.

Through these reflections, the Manager began to construct meaning. By using the notions of ‘residual competency’, and ‘management intensity’, she began to develop knowledge about managing interorganisational relationships. This knowledge helped her to understand the value of congruence, competency and complementarity within interorganisational relationships. She came to believe that complementarity could be strengthened where, not only the Hospital, but also she, lacked technical competency. The Manager observed that when she ‘removed herself’ from direct involvement in service delivery, that is, she limited the routines that she enacted with the provider, then the interorganisational relationship functioned without her. She found this required her to rely on other nurse managers to work with the service providers. The Manager also found, in contrast, that there were more occasions of tension for the nurse managers with the near-core clinical support service providers. The concept of residual competency within nurse managers helped the Manager make sense of this. Nurse Managers, with higher levels of knowledge about these near-core clinical support services, enacted more controlling routines than the Manager.
The Manager developed a sense of a pattern in this dynamic balance between her own, and nurse managers’ residual competency, and relationship functioning. When tensions arose between nurse managers and the near-core clinical support services providers, then the Manager enacted routines to bring the providers and the nurse managers to mutual understanding so that inter-relating behaviours could be adapted to achieve improved functioning. These patterns of social interaction became established within the near-core clinical support services interorganisational relationships. The Manager continued to sense these contextual attributes of residual competency and management intensity as contributing to her assessment of ‘acceptable symmetry’ between her Hospital and the interorganisational relationship providers, and within the interorganisational relationships themselves.

In the non-clinical support services however, there was less complementarity. The Manager’s narratives suggest that she perceived that peripheral non-clinical service providers’ site managers were not always experienced in the Hospital environment and its needs. Her sense-making about this, as higher residual competency in the Hospital, might explain why the Hospital managers perceived that they could deliver these services themselves. The Manager’s would often say when dealing with complaints that ‘everybody knows something about food. They all therefore think they are experts’.

The activity ‘doing the provider’s business for them’ is another of the Manager’s perceptions about residual competency in the Hospital and a reduced level of complementarity between the Hospital and the external provider organisations. This comment expressed the managers’ sense-making that they were beginning to teach the provider and that they felt that the provider had not kept abreast of the Hospital’s emerging requirements. This process led ultimately to the Human Resources provider being replaced. The Food and Environmental Services interorganisational relationships experienced a more traumatic outcome. Over time the Manager constructed a perception that these services could be better delivered by the Hospital rather than the external provider. This perception came to be constructed by others as well. Contributing to the Manager’s sense-making was her knowledge about the status of the services employees and their employment by the Hospital. This meant that technical ‘know how’, or intellectual property, would be retained in the Hospital.
so that the cost to transition to Hospital accountability would be negligible. The provider in these interorganisational relationships, unlike the near-core clinical support services providers, had low relationship specific assets at the Hospital. The Manager sensed that this meant less exposure for the Hospital in the event that the Chief Executive agreed to cease the interorganisational relationships.

While complementarity enabled the Hospital to focus its resources on the core competency of nursing, there were occasions when residual Hospital competency created tension within the near-core clinical support services providers. Two of these occasions related to the Pathology Services and the Pharmacy Services providers. In the situation of the Pathology Services event, an issue emerged from continuing frustration experienced by two senior Hospital clinicians from the Intensive Care Unit and the Emergency Department. The Pathology Services provider maintained a difference of clinical opinion about their appropriate response times to ‘urgent’ patient blood test requests from clinicians in Intensive Care and the Emergency Department. After months of frustration these clinicians made their own arrangements to perform these tests in the Hospital with equipment hired by the Hospital. This was an ‘event’ when internal Hospital competency threatened an aspect of the Pathology Services provider’s services. Numerous discussions involving the Manager, the Chief Executive, the clinicians and the Provider were required to resolve the problem.

A second ‘event’ involved the Pharmacy Services provider. The Manager of Finances engaged an external consultant to evaluate the drug impress and pharmacy supply system. In addition, the Hospital’s health funds contracts manager was a pharmacist by training. The residual competency within these two Hospital managers enabled them to engage in in-formed discussion with the Pharmacy Services provider on matters relating to the Provider’s business. Discussions became heated, frustrating and protracted with legal representation engaged by both the Hospital and the Provider. Through the negotiations the Provider’s pricing structures became more transparent to the Hospital. The Manager sensed the ‘atmosphere’ of the interorganisational relationship became tense for some of its members and synergistic functioning waned for some time.
For the researcher/manager these ‘events’ made sense in terms of ‘residual competency’. In both situations, it appeared that where the Hospital possessed residual competency, there was a chance that tensions could arise. Residual competency appeared to affect the level of complementarity which, in turn, impacted on the quality of interactions with the external providers. When this happened, the Manager reflected that she recognised that she was likely to be engaged in repetitive and protracted management routines, often embodied with conscious emotions, such as anxiousness, frustration, nervousness and even the adrenalin of power. The Manager came to understand her high level of management response to such as events as ‘high management intensity events’.

Complementarity enhanced the Manager’s perception of ‘acceptable symmetry’ by creating a mutuality of interest borne of strong interdependence. From such sense-making the possibility of a relationship synergy could emerge. This might explain why the clinical support services relationships worked successfully for so long without formal governance structures and contractual management. It might also explain why the Hospital ‘outgrew’ the Human Resources Services provider and eventually dissolved the Food and Environmental Services interorganisational relationships.

5.3.1.3 Acceptable Symmetry: Summary

Acceptable symmetry has been identified as a contextual interpretive frame that affected sense-making. It was a ‘tacit knowing’ structure that influenced the Manager’s sense-making and management activity. It was embodied in explicit activities that the Manager and others, implemented to encourage and align the interorganisational relationships more closely to the Hospital’s interests as they perceived them. In this enactment, this contextual interpretive frame is closely associated with the ‘Personal Orientation’ interpretive frame/dispositional sense-making filter.

The Manager’s narratives suggest that she possessed little consciousness that she purposely engaged in activity to create compatibility within the interorganisational
relationships. This was the situation across the six interorganisational relationships. It was only during her reflective interpretations that the researcher/Manager developed her awareness that differences in her management involvement with different interorganisational relationships may have been influenced by an interpretive frame that affected her sense-making about compatibility. The Manager (also the researcher), subsequently identified this as one of three tacit, dispositional sense-making filters, through which she made evaluations about contextual cues and enacted her responsibilities with the interorganisational relationship providers. This dispositional sense-making filter influenced the manager’s ongoing sense-making process about how social interactions and services provision met an implicit set of standards against which she measured, or made decisions about, the effective functioning of the relationship. She enacted routines, depending on her sense of the immediate context, combined with and integrated with other contextual influences and filters.

It is noteworthy that researchers in the area of strategic alliance formation conclude that the alignment of culture and mutual benefit expressed through a shared sense of purpose is important in alliance success. This interpretive research identifies that managers who implement interorganisational relationships also need to feel this alignment at the actor level if the strategy is to be effectively implemented. The next subsection examines the contextual interpretive frame of ‘Relational Ties’ in interorganisational relationships functioning.

5.3.2 Interpretive Frame: Relational Ties

The following section considers the influence of relational ties in the interorganisational relationship management process.

5.3.2.1 Meaning

This contextual interpretive frame refers to the Manager’s sense of connectivity between herself, her ‘agency’ and with others, most particularly members of the interorganisational relationships. It incorporates the Manager’s sense of ‘self” in
relation to others, but also includes relationships more broadly between members, at all levels, in the interorganisational relationships. The Manager sensed elements of inclusion, purpose and appropriateness, involvement and communication using this frame.

5.3.2.2 Cues and the Manager’s Sense-making

There were cues within the interorganisational relationships contexts ‘activated’ this contextual interpretive frame, and stimulated the Manager’s sense-making. These are illustrated in the following discussion.

Cue: Social Accounts

Interorganisational relationships bring together actors with different identities and allegiances to deliver services. Researchers have begun to explore the importance of ‘relationship’, particularly as it relates to sense-making and sense-giving in decision making and construction of organisational knowledge (Doz & Hammel 1998; Boddy et al. 2000; Lasker et al. 2001; Yli-Renko et al. 2001; Hitt et al. 2002; Johnson et al. 2002; Maitlis 2005).

Social actors construct accounts from interactions with other actors. Activities are interpreted through these accounts which are reflected upon by others and, in turn, their interpretations are absorbed into sense-making processes. Interpretations will be influenced by tacit knowledge stores that include institutionalised rules and routines, and sense-giving by leaders and other stakeholders (Maitlis 2005). Hence, as different actors and organisations are brought together in the interorganisational relationship context, knowledge is reinterpreted during daily activity. Through social interaction, ties are constructed that contribute to building intangible connections to form the ‘glue’ between parties in the interorganisational relationships.

The managers in this research perceived that many routines contributed to forming social ties, although the Manager’s reflections suggest that she perceived some social interactions to be more constructive than others. This was illustrated in the Manager’s reflections about the Human Resources provider partner and the Diagnostic Imaging
Services provider. In the first instance she was ‘struck’ by her feeling of being ‘caught’ between a relationship the Provider had with her Chief Executive, and her own relationship with the Provider. Within the Manager’s narratives, metaphors are used to describe her perceptions of some of these relationships. The Manager interpreted private meetings between the Provider and her own Chief Executive as a high-level control process, by the Provider, to enable sense-giving routines between them. Such events ‘fuelled’ some anxiety in the Manager and others.

There is also a suggestion in the narratives that the Manager perceived gender as a constituent element in selected interorganisational relationships. The multiple ways in which this interpretive frame entered and influenced the Manager’s sense-making processes have not been fully explored in this research but could be the basis of further investigation. Metaphors, such as ‘the boys club’ and the ‘mateship model’, as well as references to school mates and football conversations, and her own reflections about having to be careful with the Human Resources provider partners, suggest that the Manager viewed some contextual cues through a gender frame.

The Manager was ‘struck’ by her feeling of comfort with the new Diagnostic Imaging Services provider and its professional approach to negotiating a service agreement. This provider demonstrated behaviours that called forth different responses from the Manager. The Manager built upon these social experiences with interpretations that reflected her sense-making about her ‘self’ in relation to the others. On the one hand, it is possible that her positive feelings associated with the Diagnostic Imaging Services provider were compatible with some tacit knowing that embodied her routines with positive emotions. In contrast, she associated the Human Resources provider partner with some disquiet so that her enacted routines embodied a cautionary approach. These reflections support Johnson et al. (2002) who found that interaction between strategic decision-makers and those who make the interorganisational relationship work, is essential to perceptions of procedural justice and commitment. Commitment was identified as antecedent to co-operation.

Relational routines were both formal and informal. Nurse Managers perceived that they participated in more relationship-forming routines with the near-core clinical support services interorganisational relationships and with the Human Resources
interorganisational relationship. The Manager perceived that she was less involved with the near-core clinical support services interorganisational relationships compared to the peripheral non-clinical support interorganisational relationships.

Relational ties may reflect structural influences in the interorganisational relationships. The near-core clinical support interorganisational relationships involved total outsourcing of services. This meant the providers had greater autonomy so that the Hospital was less involved with the internal processes of the provider’s site operations. The clinical nature of three of the interorganisational relationships also meant that the Manager deferred to the technical expertise of these providers and her relational activities were focused around meetings concerned with services delivery. The Manager was more directly involved in the peripheral non-clinical support interorganisational relationships in which the Hospital retained responsibility for employees managed on its behalf by the providers. She made sense of this and strengthened her ties with the site managers and employees in these interorganisational relationships.

Other Hospital managers engaged in different management routines and had different levels of involvement with the providers. These differences reflect their specific roles as well as their position within the Hospital organisational structure. Their reflections to the Manager suggest that relationships developed between individuals depending on these roles, so that a layering of sense-giving and sense-making processes emerged. One illustration of this involved the Dietician, who had a close working relationship with the Manager, and the Food Services interorganisational relationship:

From a Food Services perspective … they are really governed by the dollar, whereas we would say we want to provide the food … what governs us is the health of the patient …. They were reactive rather than proactive … They would talk about the change process but would never, I don’t think, talk to the staff about it and get their involvement.

The researcher/Manager recalled one occasion when the Senior Dietician reported to her that one of the providers referred to her team as the ‘diet police’. This metaphor reflects the relationship the dieticians had with the provider to design patient meals, assist with meal modifications and to monitor nutrition standards.
The Payroll Manager assisted both the provider’s site managers and the Manager with the staffing and payroll aspects of the Food and Environmental Services interorganisational relationship. This manager reported a high level of involvement in selected management activities and recalled at interview:

There were always arguments about what was included [in the contract] and what wasn’t included. I think a lot of it had to do with the high turnover of managers. Every time a new manager came in, they did things differently and had to be re-educated or re-shown. There didn’t seem to be any succession planning, or hand-over, or education, so we had to basically train them, and I think all that stuff had to be done again. I then found all the time when we had to go to these meetings and were trying to make savings, I mean we were the ones trying to make the savings for them, and they would come up every time … and it was just like – ‘lights on no-one home’.

This same manager reported more positive feelings towards the Human Resources Services interorganisational relationship that reflected a stronger working relationship with this provider:

I think you get this relationship by me having a ‘can do’ attitude to them, and not thinking oh, they are contractors, why should I provide them with information they are supposed to know. By me actually being helpful and assisting, the Hospital gets more out of it.

These various perspectives demonstrate that sense-making to construct interorganisational relationships takes place at multiple levels. The perceptions of managers vary in ways that reflect their individual interpretations which are, in turn, shaped by their roles, position in the organisation and their experience and accountabilities. While this research has focussed on the sense-making of the Manager, these other managers’ perceptions illustrate that sense-giving by other stakeholders contributed to the Manager’s sense-making in constructing interorganisational relationships.

**Cue: Feelings**

In her narrative the Manager reflected on the comfort she experienced negotiating the Service Agreement with the Diagnostic Imaging Services provider’s corporate office.
She found that the provider was more ‘sophisticated’ and willing to discuss its relationship with the Hospital:

They were very co-operative about a Service Agreement. In fact they took the initiative and had one drafted by their own legal advisers. Their corporate machine was good at this sort of thing and I must say it was good working with them on this. There was a sense of mutual purpose and appreciation of the task. It has to be said however, that our Chief Executive made it clear that the transfer of leases from the earlier provider would be contingent on the signing of a Service Agreement first.

Nurse Managers also perceived that social ties, within the interorganisational relationships supported their functioning:

I found XX so approachable; we'd catch up and have a coffee, and I'd say “for Gods sake what's … falling apart at the seams” and she'd say "Oh my God, is that how you feel?" … and then it was resolved fairly quickly, efficiently and often it often didn't have to go to the Clinical Services Partnership meetings.

And further:

She is very task orientated, so it’s very hard, and that's what I mean about the relationship, but in fairness to YY he will be quite amicable I know when we meet – it’s just tying him down. So it is that - it’s a big component of it as well, and … resolution that is a big component. I mean I know there are some people I can ring up with an issue and say this has become a problem, and I know they will take it seriously.

Positive feelings enhanced integration and interorganisational relationship functioning. *Qua persona* relationships enabled such interactive routines as issue resolution, practice design and process redesign. They appeared to strengthen knowledge construction and relationship forming. As managers developed trust within their relationships, new understanding created a stronger basis for cooperation. Such dynamic changes contributed to synergy and strengthened interorganisational relationship functioning.
Leadership was also important in creating relations and social ties. Nurse Managers sometimes commented on the ‘soft’ line leadership for the near core clinical support services. One Nurse Manager commented:

They don't report to anybody within the organisation, there doesn't seem to be that impetus to drive it and move it forward. That's not a criticism of anybody in Pharmacy, just the process. Maybe if we were to sit down with the Pharmacist and look at what changes pharmacy, sort out a number of issues for them - then we can say, well, how can we get the best service from you guys within your scope? A win/win for everybody!

The Manager’s narratives suggest that interorganisational relationship functioning was enhanced by positive feelings about the interorganisational relationship. The researcher’s reflections, however, suggest that the Manager’s consciousness about management routines to build and nurture social ties was not an embedded pattern of behaviour. Rather, connectedness was consequential upon interaction. Hence, the Manager appeared not to actively construct, or reconstruct, routines for this purpose, even though she and others occasionally recognised the benefits of a cup of coffee and a chat.

The finding that social connectedness enhanced positive feelings and functioning relationships, extends those from research based on structuration theory (Orlikowski 1992; Ring & Van de Ven 1992) that underlying iterative and constructive relationship building is essential in collaborative contexts. Research by Yli-Renko et al. (2001) about knowledge acquisition and exploitation concludes that positive social interactions between interorganisational relationship participants enhanced knowledge transfer and acquisition. This appeared to be the situation in the Human Resources interorganisational relationship, in its early stages. The research findings about negative feelings associated with ‘doing the provider’s business for them’, were associated with those interorganisational relationships that ended. These findings have a further parallel with those of Yli-Renko et al. (2001) where it was found that relationship quality (perceptions of trust) were negatively associated with knowledge acquisition.
**Cue: Purpose**

There was an event when the Manager was ‘struck’ by a comment made to her about her responsibilities with the Human Resources interorganisational relationship services. This cued her sense-making about her leadership and level of involvement with this provider. From this moment, she adapted her management routines so that she became more involved on a daily basis with the Provider and other managers, to develop and implement the vision for the Hospital’s human resources services. This was the devolved model. In this way the Manager adopted active sense-giving routines and guided a systematic construction, with the Provider, of the human resources services. This reflects and extends one of the four forms of organisational sense-making identified by Maitlis (2005) called guided organisational sense-making.

Over the years of the human resources interorganisational relationships, the Manager and other Hospital managers constructed ‘joint ownership’ of the Hospital’s human resources function. During this process the Hospital’s Human Resources function was legitimised through external recognition (awards). These achievements were consistent with the Hospital’s identity as a leader and innovator. The Manager engaged in high levels of management involvement, (management intensity) just as she had done with the Food and Environmental Services interorganisational relationships, and others had done with the Pathology, and Pharmacy, Services providers. It emerged, however, that high levels of involvement by the Manager, with the Human Resources interorganisational relationship were associated with ‘success’ on the one hand, but an end to the interorganisational relationship in the Food Services and Environmental Services on the other.

This research finding suggests that high levels of management involvement in constructing interorganisational relationships cannot always be associated with poor interorganisational relationship functioning. For an interorganisational relationship designed for knowledge transfer and learning, as were the objectives of the Human Resources interorganisational relationship, additional social interaction between the actors may be expected as part of the transfer and learning process. Higher levels of interaction contribute to building trust in knowledge construction, or learning, associations. Exposure to, and discussion about ideas, appears essential in these processes and constructive for relationships (Yli-Renko et al. 2001; Linder et al.
Strategic interorganisational relationships that are designed to transfer knowledge might, therefore, be characterised by a higher levels of management involvement and interaction.

In knowledge-transfer, or knowledge construction, interorganisational relationships, the level of interaction is balanced by the strategic value of the interactions, or transactions, to the client. The findings for the Human Resources interorganisational relationship tend to support this. The Manager sensed that she was greatly involved in management (high management intensity) with this interorganisational relationship. The positive emotions reported by the Manager, and other managers who were interviewed, describe a relationship for which interactions were seen as positively contributing to the interorganisational relationship’s synergistic functioning.

Unlike the other two peripheral non-clinical services, interactions in the Human Resources interorganisational relationship appeared, for a period of time, to be constructive in their contribution to interorganisational relationship functioning. Interestingly there is a suggestion in the Manager’s narratives, that activity levels and constructive relations waned as the objectives of the relationship were achieved and as the provider was no longer able to maintain greater competencies than the client. Perceptions by other managers that they were doing the others’ business for them indicated their sense-making about the provider’s competency and their response which was to act without reliance on the provider.

**5.3.2.3 Social Ties: Summary**

The perception that explicit relationship-forming routines were important, but perhaps not conscious, across the interorganisational relationships, is consistent with current debate which suggests that this process is important to interorganisational relationship functioning (Lasker et al. 2001; Hitt et al. 2002; Kern and Blois 2002; Linder et al. 2002). The formation of quality social ties appears to be an outcome that differentiates interorganisational relationships. This suggests that social relationship construction capabilities are important in interorganisational relationship managers, some of whom will be more effective than other managers. Useem & Harder (2000)
identified social networking and lateral management as key competencies in interorganisational relationship contexts. Some managers appeared able to establish qua persona relationships as part of their sense-making about the interorganisational relationship functioning. These managers made sense of their context differently to other managers and this reflection raises the possibility that competency in building social ties, both laterally and vertically, will be important in selecting those who lead and participate in interorganisational relationships.

5.3.3 Interpretive Frame: Trust

The following section considers the influence of trust in the interorganisational relationship management process.

5.3.3.1 Meaning

Trust is that conscious sense of belief and acceptance of vulnerability to another (Hutt et al. 2000) and it develops over time from repeated interactions between individuals and communities of actors (Narayandas & Rangan 2004; Ring & Van de Ven 1992; Reed 2000).

5.3.3.2 Cues and the Manager’s Sense-making

The Manager’s role as client contracts manager gave her authority and power in her relations with the interorganisational relationships providers. This position, and the Manager’s interpretation of her role, emerged as a primary contextual cue to stimulate her sense-making about daily routines in managing the interorganisational relationships. In constructing her accounts the researcher/Manager became more conscious that the routines which she had enacted during the research period may have conveyed messages of her intent to control the providers’ activities. During this reflective period she was struck by an apparent association between monitoring the providers’ service delivery and construction of trusting relationships. She sensed that she was intent on ‘getting the job done’ and perhaps not finding balances between the
providers’ and the Hospital’s needs. After further reflecting about this association she began to contemplate her emotions. In turn, this sense-making highlighted issues about her accountability. She sensed the emotion of guilt that might be associated with her not meeting her accountabilities at standards she perceived the Hospital might expect. She felt responsible to meet the competing demands of Hospital stakeholders, at all levels, more than she did for the providers in the interorganisational relationships.

In all, this reflective period contributed a deeper understanding about the fine balance between the emotions of guilt that she might experience by any failure to achieve the Hospital’s goals, her interpretations of her responsibilities to the providers, and her accountabilities to the Hospital for the services delivered to its patients and staff through the interorganisational relationships.

**Cue: Position control**

High levels of leader sense-giving lead to processes whereby sense-making is controlled (Maitlis 2005). The Manager drew on her position and authority to pursue development of service level agreements and standards within each of the interorganisational relationships. It is possible that the Manager’s high level of involvement was perceived as intrusion, or even coercion, by some of the providers, and an indication that she did not trust them. Given that each of the providers had been part of the Hospital community for several years before she came, her actions may not have been well understood by them.

The Manager perceived that the peripheral non-clinical support services had been managed differently in the period before she came to the Hospital. She often reflected that the services ‘just existed there and nobody did anything to manage them’. The absence of service level agreements concerned her. She was not able to understand how the providers were to be accountable to the Nurse Managers and the clinicians without some formally documented understandings. This commitment, and her prior experience in other organisations, underscored her sense-making to implement the routines associated with developing and implementing such agreements. This focus emerged through each of the narratives in Chapter 4.
The narratives reveal that the Manager was most involved in governance-related activities, such as formal meetings for discussions and reporting, audits and evaluations, with the peripheral non-clinical support interorganisational relationships. Other researchers (Williamson 1985; Dyer 1997; Subramani & Venkatraman 2003) have observed that governance achieved interorganisational relationship purpose. Further, they have proposed that a pattern of moderate client governance activity was more constructive in successful interorganisational relationship functioning because of implied trust (Dyer 1997). Over-governance may destroy trust. It is possible that some aspects of the findings in this research support this. The Manager’s narratives reveal much about her efforts to establish and monitor service agreements and standards for the interorganisational relationships. Such agreements were formal means to govern relationships (Gulati 1995a, 1995b; Hoecht 2002; Subramani & Venkatraman 2003) and they were perceived by the Manager as a distinct means by which to legitimatise the interorganisational relationships (Suchman 1995; Ruef & Scott 1998).

While the Manager had this focus on securing service agreements with the near-core clinical support service providers, she also sensed the considerable congruence these providers achieved by virtue of the complementary resources they brought to the Hospital. The Manager’s perception of complementarity emerged as a presentation of legitimacy in her sense-making. She acknowledged that she was not a clinical expert and so she seemed better prepared, or able, to put her trust in these providers. Beyond her efforts to secure construction of the service agreements, her routines were directed to ensuring that clinical and nursing stakeholders received the quality of service delivery that they wanted. This lower level of involvement (low management intensity) may have been due to a stronger sense of trust she held in these providers, compared with the peripheral non-clinical support providers.

The Hospital’s peripheral non-clinical support service interorganisational relationships were characterised by higher levels of involvement by the Manager. The Manager’s narratives suggest that she acknowledged the interorganisational relationship structure, as well as the strategic business objectives, contributed to her high level of involvement. Her narratives suggest that she was involved in the food and environmental services almost as though she was the line manager of these
services. Her management intensity with these interorganisational relationships suggests that she conveyed a level of her mistrust to these providers. In later periods of reflection the researcher/Manager acknowledged that she struggled to find a balance between meeting her accountabilities to ensure quality services were provided and trusting this to the provider to meet stakeholder expectations.

Research about trust also highlights strategies which organisational members adopt to accomplish trust in interorganisational relationships. In this research the near-core clinical support services interorganisational relationship providers also used different routines to protect their relationship specific investments. The dominant means were through the multiple option leases and investment in technologically advanced assets, including development and protection of intellectual property. These routines are consistent with transaction cost theory predictions that organisations which invest in relationship-specific assets are likely to invoke formalised governance structures at the outset to prevent opportunistic exploitation (Heide & John 1992; Heide 1994; Narayandas & Rangan 2004).

Each of the near-core clinical support services interorganisational relationships involved significant capital and intellectual investment at the Hospital. Apart from extended leases, over time, the providers and the Hospital also developed specific routines and patient service systems, customised to the Hospital’s doctors’ needs. These systems represented relationship-specific intellectual capital investments (Subramani and Venkatraman, 2003). Such intangible relationship assets helped to bind the organisations and increase the potential cost of relationship dissolution. From this perspective, the greater the quasi-integration between the providers and the Hospital, the stronger the safeguard they extracted to protect their relationship specific investments.

There were times when the Manager sensed that the long leases and multiple options were a disincentive for the providers to respond to her wishes for service quality improvement. There were periods and issues over which the providers maintained a level of ambivalence with respect to her requests, as well as those of Nurse Managers. This frustrated Nurse Managers and their sense-making heightened their monitoring activity in pursuit of change. These near-core clinical support services
interorganisational relationships were not described with formal service agreements until well into the relationship maintenance stage as is described in the Manager’s narratives. The Manager raised this concern on several occasions with her Chief Executive and other members of the Hospital Executive:

It was acknowledged that insufficient consideration had been given to the service side of the relationships when the leases were originally prepared. I put my view that it would be difficult to change this now and we would have to rely on a constructive relationship to encourage the provider to change. The governance mechanism was a lease and nothing more. The providers were very secure and the Hospital was ‘captured’.

In one of her narratives the Manager recalled her early attempts to develop a service agreement:

I had a distinct impression that this was not something that the Pathology provider wanted to do. They nominated a contact person. But she claimed she could not see the need for a service agreement and I felt that she resisted our attempts. She avoided responding to our proposals and would have been happy with an exchange of letters I think. I was not able to progress anything with her despite my efforts to explain the benefits to us both. The Head Office people did not appear interested and did not rush to support the site manager when I tried to work at that level.

The Manager felt a sense of powerlessness in the face of this inertia. Similar perceptions were constructed by the Manager of Finance when contractual discussions with the Pharmacy Services provider became difficult. His comments that “if we had our time again, we would make sure we negotiated these arrangements properly in the first place!” expressed his frustration. During their private reflective conversations these two managers recalled how the Hospital context had changed and there were many more pressures that made it important to have a means to manage the providers’ service accountabilities to the Hospital Board and to its patients. The individual interorganisational relationship contexts did not appear to parallel this change, particularly to the extent that old leases (now perceived as limits by the Hospital) continued to define the purpose of the relationship between the parties.
During her reflections and her writing the researcher/Manager questioned herself about her focus on implementing service agreements. She was not particularly conscious that this was the result of any mistrust of the providers. For her it was more about collaborating in routines that would accomplish service delivery standards for patients for which the providers had accountability and the Hospital had a duty of care. She pondered a number of questions such as: ‘Was this really due to a lack of trust she had in the provider or was it perhaps due to her perceived lack of control over the provider?’ Without these agreed service standards was it possible that the Manager and the Nurse Managers, felt vulnerable? Did this vulnerability stem from having to be dependant upon the provider? Perhaps this did mean mistrust?

Monitoring, as governance, is essential to achieving productive levels of trust but over-monitoring may undermine trust between parties in a relationship (Gulati 1995a; Das & Teng 1998b; Boddy et al. 2000; Das & Teng 2000; Jeffries & Reed 2000). The Manager’s high level of involvement in the Food and Environmental Services interorganisational relationships diminished the site authority of the external provider. This ‘over-governance’ may have compromised the level of trust within the interorganisational relationship.

On reflection, the Manager came to suspect that she had intervened with the Food and Environmental Services provider and that this possibly contributed to poor functioning of the interorganisational relationships. The Manager recalled, in her narratives, the routines in which she was involved, such as contract design and negotiation, budgeting, meetings and discussions, monitoring service standards, changing delivery processes and striving for better outcomes. There was one occasion when she was ‘struck’ by the effect of her decision to assume responsibility for the employees under the Provider’s management. By adopting this approach the Manager increased her controlling routines, such as authorising staffing and monitoring wages expenditure. These were routines that the Provider perhaps should have undertaken. On reflection the Manager began to acknowledge that her sense-making and actions left the provider with diminished control and autonomy.

Throughout her reflections about the Food and Environmental Services interorganisational relationships, the Manager remained ambivalent about her level of
involvement. She often ‘justified’ her approach in terms of the structure of the management services delivery model for the food and environmental services. In her mind this compounded difficulties for the interorganisational relationships’ functioning. The Manager felt unable to trust the Provider to take full responsibility for the Hospital’s employees and she was not confident that the Hospital could, or would be happy, to accept ultimate responsibility if something happened to them. She retained duty of care and this was in a stark contrast to the near-core clinical support interorganisational relationships.

5.3.3.3 Trust: Summary

The Manager engaged in routines, such as meetings, setting standards and monitoring them in which she used her position and authority for the purpose of exercising control and influence in the interorganisational relationships. The Manager, in turn, perceived that the providers also engaged in passive resistance as a way to retain independence and their own authority. Both the Hospital and the providers adopted strategies to exercise and gain ‘control’ in the interorganisational relationships. Such routines embodied feelings of vulnerability and trust towards the other as the Manager, and others, constructed the interorganisational relationships. Managers made sense of the collaborative contexts differently. Variations in this sense-making, as ‘events’ occurred for members on a daily basis, contributed to the Manager’s routines as she responded to issues and opportunities to develop and adapt the process of interorganisational relationships construction.

5.3.4 Interpretive Frame: Managerial Cognition

Managerial cognition is a contextual interpretive frame that is strongly associated with the Manager’s interpretation of her role and the exercise of her experience as a manager. The following section discusses some of the cues associated with managerial cognition.
5.3.4.1 Meaning

The Manager possessed a strong sense of her responsibilities for the Hospital’s ‘outsourced services’. This was manifest in a strong managerial cognition frame through which she interpreted actions and events within each interorganisational relationship context. Her narratives reveal that she practiced a variety of routines. The Manager applied tacit knowledge structures, such as rules, processes and ‘ways of doing things’, and sensed their connection to effective outcomes (Mingers, 1995; Chikudate, 1999a, 1999b). This sub section addresses the adaptive process in which managers engaged to operate within the collaborative context.

5.3.4.2 Cues and the Manager’s Sense-making

Selected cues within the interorganisational relationship contexts that ‘activated’ this contextual interpretive frame, and stimulated the Manager’s sense-making, are discussed below.

Cue: ‘Tried and True’ Routines

The Manager’s reflections suggest that despite the diversity of the six interorganisational relationships, there were many traditional management routines tried in the collaborative context. Actors responded to each other with ‘tried and true’ ways of behaving (the institutionalised rules and routines of their respective organisations). Their interactions were borne of ‘tacit knowing’ constructed from prior sense-making experiences. Routines included discussions and meetings, planning, issue resolution processes, monitoring, reporting and evaluating. Where these routines contributed to effective functioning accompanied with positive feelings, those routines were reinforced as appropriate behaviours in the interorganisational relationship context. In this way, knowledge was transferred about collaborative interaction.

Findings in this research are consistent with emphases in the research literature about interorganisational relationships where it is suggested that partner selection, service specifications and contracts negotiation are fundamental to functioning
interorganisational relationships (Linder et al. 2001; Goolsby 2002; Goolsby & Whitlow 2003; Hunter & Healey 2003). The Manager’s narratives indicate that she made sense of her role and responsibilities through much activity that is traditionally associated with operational responsibilities. Transaction cost theory (Williamson 1985; Hennart et al. 1999; Dyer 1997) proposes that each of the Manager’s activities is a ‘transaction’ and also a contributing cost of the interorganisational relationship. This economic perspective places value on reducing client transaction costs so that resources can be redistributed to core business activity. The cost effectiveness of interorganisational relationship functioning is thus traditionally associated with reducing client management activity. The findings for the near-core clinical support services interorganisational relationships tend to support this proposition that client management activity is reduced by transferring effort to the external provider. However, this situation is not so clear for the peripheral non-clinical support services in this research.

The Manager’s narratives identified a high level of client management routines associated with creating acceptable symmetry, building relational ties and trust, and with routines to encourage the providers to ‘my view’. Further, where there was perceived to be an association between high management involvement and negative-feeling-enriched behaviours, this suggests that the functioning interorganisational relationship had not achieved the synergistic levels that Lasker et al. (2001) associated with synergistic functioning.

The level of involvement of the Manager in operational routines has been juxtaposed against perceptions by the Manager, and other Hospital managers, that qua persona relationships were most effective in achieving interorganisational relationship functioning. This finding about relationship management is consistent with more recent conceptualisations in research investigations that social ties and networks between members are important in collaborative structures (Lasker et al. 2001; Lasker & Weiss 2003; Hitt et al. 2002) and may in fact reduce emphases on operational routines. The quality of interpersonal relations between the parties, particularly amongst those members at the operational levels of the interorganisational relationship, has the potential to improve relational functioning and outcomes.
The findings in this research suggest that there may be a lack of connection between the Manager’s sense of her role (responsibilities), and her accountabilities, in relation to delivering the contracted services, and any sense she may have had of an opportunity in her responsibilities to also consciously construct effective *au persona* relationships. Among the questions that this raises are the following. Can relationships be consciously constructed? The theory of frames would suggest so. Can managers overcome dispositions, institutional frames and scripts to reconstruct (adapt) behaviours to suit collaborative routines? Emotion and motivation theory suggests that they can. Can managers who concurrently manage in traditional and interorganisational relationship contexts ‘switch’ and adapt constantly? While the Manager, on reflection, perceived that achieving an ‘acceptable symmetry’ between the parties, and strong ‘relational ties’ contributed to effective functioning, there is less suggestion that she consciously reconstructed routines in order to reduce her operational involvement.

This research suggests that outsourcing services through interorganisational relationships may not diminish client operational involvement, as often suggested. Conversely, it is possible that managers who engaged in this level of activity may not be effectively making sense of the collaborative context. By resorting to traditional ways of management, influenced by interpretive frames and filters that reflect institutionalised ways of behaving, managers may stifle interorganisational relationships functioning.

**Cue: Emotions and Events**

It has also been identified that some of the managers’ routines were embodied with emotions. This research proposes that managers’ emotions act like ‘pointers’ to knowledge structures and routines that are ‘at odds’ with the new collaborative context. In this way emotions become cues. If it is so that emotions can be associated with *crucial experiences*, then managers can learn to recognise these crucial experiences as opportunities to trigger reflection and reproduce previously legitimated, or taken-for-granted, organisational actions. The Manager’s narratives suggest that she did not always recognise these opportunities. For instance, the statement that ‘it was like hitting your head against a brick wall’ may be the response of a manager who has persisted with an approach that is just not working.
Unfortunately the Manager did not recognise this at the time, and so she persisted with routines based on old knowledge structures. A failure to make sense of the context prolonged ad hoc, fragmented behaviours that isolated her from a collaborative approach and destabilised the interorganisational relationships. Conversely, there is a suggestion that despite her sense-giving with other Executive stakeholders, some time passed before she was able to persuade them to engage in more direct leadership, as eventually occurred with the peripheral non clinical support services.

The Manager’s narratives identify examples where the Manager failed to engage in reflexivity to resolve problems and to redefine her involvement. In these situations she persisted with old routines so that the problems become bigger. Her response was to create a ‘battle’ that she tried hard to ‘win’. This was the situation with the Food Services provider. She failed to see that the problem, despite the emotion that she acknowledged in her recall, was an opportunity for learning. Why was this so?

The Manager was very involved in the Food Services and the Environmental Services interorganisational relationships. The context of these services and specifically, the structure of the relationships wherein the provider managed the Manager’s employees prompted active sense-making. The Manager perceived that she was ‘caught’ between provider’s authority to deliver the services with her employees and her own interpretation of her line responsibility, a context that did not match with her traditional ‘tools and maps’ for meeting these responsibilities. This context thrust her into a sense-making process to find adaptive behaviours and establish new routines. By all accounts, the Manager’s narratives indicate that she was not particularly successful in evolving these new effective routines. It appears that she was not able to assess this particular context and eventually the interorganisational relationships unravelled. On reflection it appears she was committed to a contextual interpretive frame that was so intrinsic to her world view and her identity, from which she could not back down. While she recalled being exhausted at the end of the ‘battle’, she was also satisfied, believing that she had pleased her employees, the union, other staff in the Hospital and, to some extent, her Chief Executive, who she recalled, ‘backed down’. She clearly approached her management of this interorganisational relationship as a zero-sum game, and she enjoyed the win!
While this was the situation for the Food and Environmental Services interorganisational relationships, the Manager seemed better able to reconstruct routines that were effective, for a time, with the Human Resources interorganisational relationship. Learning and adaptation processes were the essence of this service relationship. It is possible that this context predisposed the Manager, and other managers in the Hospital, to accept the construction of new routines specific to managing people. The objectives of this interorganisational relationship made it ‘safe’ to engage in discussion around different points of view. The Provider’s approach was to encourage reflection and supportive reflexive action. These processes occurred in private and confidential settings between managers and the provider’s senior Human Resources Adviser. Group discussion and reflection also occurred within the Human Resources Function Team, established by the Manager. The honesty and vulnerability surrounding these processes contributed to the construction of strong bonds, trust and functioning relationships. It was not until the end of the research period that the interorganisational relationship began to unravel. The Manager’s narrative related this to certain individuals. This reflection perhaps highlights the criticality of specific competencies in managers where it is necessary to deconstruct and reinstitute new rules and routines.

There were occasions when the Manager did engage in reflexive interpretation. Her narratives recall occasions when she was ‘struck’ by events that led her to reflect and then move into an adaptive behaviour processes. Examples of this include, when she approached the Human Resources partner more cautiously at the executive decision making levels, when she adapted her leadership of human resources and styled participatory and collaborative routines with the Human Resources provider. Another example was found when she ‘stood back’ from the Pathology Services interorganisational relationship for a while during the service agreement discussions. This appeared to facilitate prolonged sense-giving and sense-making so that, with the passage of time new knowledge and routines could be enacted. Another example was when she responded to the Diagnostic Imaging Services provider’s corporate approach and allowed them to take the lead in service agreement discussions. These behaviours heralded contextual sense-making and reconstructed routines adapted from traditional line management routines anchored in unitary control and authority.
One further occasion occurred when there was a breakdown in relational ties and traditional operational routines, during the time the Finance Manager was unable to negotiate a mutually acceptable Pharmacy Supply Agreement. This became an ‘event’ for the Manager and stimulated her sense-making to find new routines where old ones no longer applied. Repeated patterns of failure to reconstruct routines had occurred during this time and the negotiations were only concluded effectively, after the research period, when a new manager took over and resolved the issues effectively. During this period the Manager, who sensed the ongoing difficulties for her colleague manager and the Provider, adopted more conciliatory routines with the Pharmacy Services provider, to balance those of her colleague, until the issues were eventually resolved. This is reminiscent of the notion that ‘sense-making is seldom solitary but instead, is inherently social … [embedding] people … in sense-making predicaments [that] must take others’ inputs (interpretations) and outputs (actions) into account at the same time that they are desperately trying to make their own sense of a situation’ (Kramer 2002, p. 2).

Throughout the daily implementation of interorganisational relationships there were difficulties that were perceived by managers as ‘events’. Managers frequently engaged in sequences of activities to redesign services, resolve service issues and match stakeholder satisfaction with expectations. In the context of the near-core clinical support services interorganisational relationships these activities were often associated with feelings about a ‘lack of control’. One of the Nurse Managers in interview commented frequently on this with phrases such as:

Service issues keep getting put on hold because no-one has the time to deal with them - but they tend to fester.

What is the accountability? [It] is not obvious when there are issues.

Three weeks to one month later I said - so all the improvements with Pharmacy are great? - nothing has changed.

What's in it for me, and it’s a big thing, what's in it for them - not a lot. The less they provide to us that they … get away with it why would we strive to provide more service - I mean it’s a reality, its human nature.
Quite often we end up losing because we are not getting the service that we expect.

Hospital inpatients held the Hospital staff responsible for the near-core clinical support services. This was also identified in the Manager’s narrative:

Because of our co-location and our efforts to make the services seamless there can be a tendency in the patients’ view for the Hospital to carry all the accountability for service quality and price. Ensuring alignment of standards and a vision for best practice between the parties is a major task for those working in the relationship. On the whole it works pretty well with the imaging service provider. It is high tech and we are equally proud of being at the forefront. Inpatients receive priority and there are rarely problems of timely access.

Nurse Managers shared service responsibility with the interorganisational relationship providers. Patients often did not associate specific aspects of their care with another provider so those service problems became those of the Hospital. This was an aspect of the interorganisational relationships context that stimulated sense-making for Nurse Managers who, the Manager perceived, sometimes struggled to share ‘control’ of patient care paths with multiple providers. The Manager’s own reflections on this contextual influence led her to believe that nurses liked to ‘control’ the patients’ care experience. This was a key part of their professional training and experience; not feelings of being disempowered, not being in control and the absence of leadership. If this was the situation, then standard ways of behaving for nurses were challenged by the collaborative contexts.

When there was a perceived inability to resolve service issues at the operational level despite perceived efforts to evolve new routines to address them, the issues were escalated to the Manager. Her response was to most often engage in interactive discussions with the providers and stakeholders. Sometimes these discussions only resulted in short term remedies rather than deep change. The perception by Hospital employees was that the providers felt little obligation to change their institutionalised routines either. Over time this led to pessimism amongst some nursing staff and a resignation that nothing could be done. Sometimes the nurses responded by modifying their own routines on the wards to accommodate anticipated provider responses. For instance, they would order impress or pathology tests as ‘urgent’ or
they would ‘raid’ another ward for stock, or stockpile supplies. There were other managers who discovered that strengthening social ties with the provider’s site employees did enable solutions to be found for local problems. These managers adapted their routines to incorporate more informal gatherings with provider personnel.

Having reflected further on these experiences, it appears that conventional management activity to control and direct relationships does not work well with external partners. It does appear that it is ineffective to treat interorganisational relationships as though they are orderly, linear and predictive. Interorganisational relationships are more dynamic and pluralist than this. They are constructs for exploration, experimentation and exchange. An open mind to flexibility, adaptation and compromise, as well as absorption of alternative views, is essential to reconstructing new knowledge, patterns and rules so that relational routines and competences emerge.

5.3.4.3 Managerial Cognition: Summary

Organisations emerge and, thus, are adaptive. Researchers have identified that managing interorganisational relationships requires a unique capability, the existence of which differentiates organisations in the marketplace (Hagedoorn & Schakenraad 1994; Gulati 1995a, 1998; Hitt et al. 2002; Hutt et al. 2000; Stuart 2000; Chikudate 1999a, 1999b). Useem & Harder (2000) observed that organisational forms resulting from interorganisational relationships were characterised by specific managerial routines and capabilities. Of particular significance was the requirement for ‘lateral management’. Lasker et al. (2001) also reported collaborative routines as a necessary capability to achievement of effective functioning in community health networks. Such views extended earlier work by Chikudate (1999a, 1999b), who also observed how Japanese businessmen needed to reorientate their cultural view so that partnership with external cultures would enable effective relationships. The findings from this research extend this research field by investigating a selection of interorganisational relationships in a health service organisation wherein the
5.3.5 Interpretive Frame: Personal Orientation

The final contextual interpretive frame is that relating to the personal orientation of the Manager. This influence, as with the previous ones, is difficult to consider in isolation because each interacts with the other to create the complex behaviours that managers display in the context of interorganisational relationships.

5.3.5.1 Meaning

Personal orientation refers to the Manager’s disposition to consistently, construct knowledge, or interpret events, and enact in a particular way. Such a disposition could manifest as a ‘bias’. This is consistent with the propositions of Achilles (1999) and Damanpour (1991) who proposed that outcomes were less important as drivers of change. The Manager’s personal experience, knowledge and interpretation of her role, responsibilities and accountabilities, contributed to construct her ‘view of her world’. As an agent of the Hospital she adopted a commitment to act responsibly to implement hospital strategy and achieve its interorganisational relationship objectives, even though her ‘self’ shaded how she managed this implementation.

5.3.5.2 Cues and the Manager’s Sense-making

Selected cues within the interorganisational relationship contexts that ‘activated’ this contextual interpretive frame, and stimulated the Manager’s sense-making, are discussed below. This frame was also identified as a sense-making filter because of the Manager’s strong commitment to enact routines that embodied her emotional and personal commitment to doing what she believed was expected of her.

Cue: Legitimacy

Legitimacy is a perception that defines actors’ reactions to organisation as they see it. Suchman (1995, p. 574) defined legitimacy as a generalised perception or assumption ‘that the actions of an entity are desirable, proper, or appropriate within some socially
constructed system of norms, values, beliefs and definitions’. This notion of what was legitimate and acceptable and ‘correct’ was an ‘unnegotiable’ filter for the Manager. Through this filter the Manager assured herself that she could be comfortable and accountable to her ‘primary organisation’ and her employer, the Hospital.

A distinguishing attribute of the Hospital was its not-for-profit status. This had enabled it to assume a strong focus on patient care and satisfaction as an indicator of service performance and outcome. Any diminution in reported satisfaction levels reflected poorly against the Hospital’s stated mission and values. The Chief Executive was often heard to recount a story about the Hospital and its mission, using the organisation’s emblem because it embodied the message in symbolic form. He told this story to all new Hospital employees to encourage them to focus on care of the patient in all decision-making as this was the primary Hospital objective. The story instilled in employees, including the Manager, an orientation to the patient that became a guiding principle across all Hospital activities.

In contrast to the Hospital, the external providers who were members of the six interorganisational relationships were for-profit organisations. It is possible that these fundamental fiscal attributes contributed to construct, different social and economic behaviours, cultural norms and value systems. The interorganisational relationships providers had short-term orientations that kept them primarily focused on monthly results and margins. They found it more difficult to accommodate the Manager’s constant striving for service quality based on the Hospital’s ever important client expectations and their valued patient satisfaction measures. Performance measures and incentives were different between the organisations. In the not-for-profit Hospital, during the early phases of this research period, Hospital employees found decision-making, driven by cost constraint and service compromise, at odds with their values. Hospital employees tended not to express the same economic focus as their for-profit colleagues.

These differences contributed to an ongoing tension that was expressed through the managers’ level of involvement in various routines, but which also increased coordination costs for the Hospital. Slow response times by the providers to hospital
initiatives, and demands for improved service quality levels, led to many repetitive routines by the Manager, such as describing service expectations, receiving and responding to complaints, giving advice and negotiating. These activities were most often orientated towards the Manager’s view of how things should be.

However, as the Hospital’s growth strategy was enacted, health funding organisations began to resist its call for increases in Hospital funding rates. Discussions about ‘value for money’ began to emerge within the Hospital. Comparisons were made about product and service quality, in the period before the strategic outsourcing was implemented. Managers constructed accounts that reflected the pressure on them to manage their resources and contribute to Hospital margins. The Hospital’s middle managers also began to understand that times had changed. The margins made by the external service providers were perceived as Hospital costs that should not be sustained.

Over the period of the research, the Manager’s sense-making of growing pressure to reduce the Hospital’s costs of services translated into even more involvement to manage her peripheral non-clinical support services. There is much in the official records of the Manager that indicates analysis of costs and quality of services as measured by patient satisfaction and staff surveys. Efforts by the Manager in this regard threatened the providers’ margins because at the same time that she applied pressure to improve service outcomes she was resistant to meet their demands for increase contract prices. Those interorganisational relationships where the Manager had direct line influence felt these routines the most. In the final year of this research the Manager and her closest advisers, began to believe that they could deliver better services than their providers could, and for less cost.

Complaints from stakeholders to the Manager about the providers became more commonplace. Stakeholders used this as a form of sense-giving to the Manager. The Manager also experienced approaches from some shop stewards who asked her on several occasions if she would consider returning food services back to ‘in-house arrangements’. Mounting pressure and the Manager’s desire to meet her Board’s growing support for a review of the Food and Environmental Services interorganisational relationships led eventually to her recommending that these
interorganisational relationships be dissolved at the end of the provider’s contract period in December 2001.

Sense-making, and sense-giving, processes at all levels within the Hospital constructed a melting-pot of new ideas and stimulated the reconstruction of management behaviours, some of which were adapted from the for-profit hospital sector. The Manager recalled reflecting upon these developments and recalling experiences from employment in other organisations where cost control was part of the ‘way she did things’. It is possible that the Manager absorbed these changes as an affirmation of her approach to controlling contracted costs with the peripheral non-clinical support interorganisational relationship providers. In the context of the Food and Environmental Services provider, the Manager did not address the provider’s concerns about contract viability in a way that satisfied the provider. She perceived that her financial approach was supported at the executive level and implemented reporting routines with the providers that reflected these requirements for financial, as well as patient satisfaction. In turn, she reported monthly to her Board on these outcomes. It was the Manager’s view that the providers struggled to adapt to this new environment with creative and adaptive service changes so that, in time, this contributed to the dissolution of the interorganisational relationships.

For the near-core clinical support services, the patients were billed through their health fund memberships and other out-of-pocket expenses. Thus financial accountability was generally not experienced by the Hospital since the service providers themselves assumed this.

**Cue: Interorganisational Relationship Objectives**

The Manager was committed to working with the interorganisational relationship providers to deliver the services which the Hospital believed it had contracted. This commitment became a cue in support of the Manager’s Personal Orientation interpretive frame.

In the Human Resources Services interorganisational relationship, the learning model on which the service was based, paradoxically, also became its downfall. There was a perception held by a growing number of managers that the provider’s services were
no longer as sophisticated as they required. Through the Human Resources Function Team and through private meetings with the Manager they used sense-giving processes to convey these perceptions to the Manager. In time, and with reflective periods after sense-giving, the Manager began to formulate a view that the Hospital may have outgrown its external provider. The Manager became similarly inclined to the view that the provider’s services had become transactional. The provider was no longer delivering the value-adding support that more capable managers required in the complex hospital setting. The Human Resources Services provider struggled to effect adequate protective governance mechanisms, so that as the relationship began to falter, its vulnerability grew and when its contract period finished, the contract was not renewed.

A similar fate was experienced by the Food and Environmental Services provider although the Manager acknowledged the efforts of the Provider to respond to her wishes for better patient food, for improved staff management and quality systems. Over time, and with sense-giving by her own employees and other managers, the Manager also came to perceive that tensions within the relationship were having a negative impact of the interorganisational relationship. Further, the Manager had engaged in sense-giving processes with her Chief Executive to suggest that the Hospital could deliver the services in-house for less cost. These sense-giving routines by the Manager extended over two years until her Chief Executive finally supported her recommendation. The interorganisational relationships were wound up shortly after and the support services successfully returned to in-house arrangements.

The relationships between the near-core clinical support interorganisational relationships and the Hospital were much stronger. The services these providers delivered were fully integrated with the Hospital’s core patient care service and they were delivered by organisations with high levels of capability. There was a more arms-length relationship with the Manager and other stakeholders who recognised and respected their professional service delivery. It was also recognised that the near-core clinical support interorganisational relationships were ‘beyond reach’ because of the very secure leases the providers had negotiated. This gave them ongoing service guarantees and the longer they worked with the Hospital, the stronger their relationships became. There was no residual competency in the Hospital to enable
them to compete for delivery with these providers, as there had been with the peripheral non-clinical support services providers. While sense-making to improve service quality outcomes continued to dominate the Nurse Managers, and the Manager, they accepted that this would be incremental over time. This success was due largely to the provider leadership at the time and some were more amenable than others. At the end of the research period Nurse Managers continued to express frustration and resignation about change being slow to achieve. When asked how they felt overall about the near-core clinical support interorganisational relationships providers, however, they each responded positively about the functioning.

**Cue: Context and Self**

Through this reflexive interpretive research an association has emerged between interorganisational relationship management processes and managers’ contextual interpretive frames (Chikudate 1999a, 1999b) and dispositional sense-making filters. Managers draw cues (influences) from their environment, and drawing on tacit knowledge, they select and impose meaning to inform action responses. This process is shown in Figure 5-1:

**Figure 5-1 The Self in Interorganisational Relationship**

Source: Developed for this research
The Manager’s sense-making in response to cues in the interorganisational relationships context also contributed to construct the interorganisational relationships. Reflexive interpretation over the extended period of this research led the researcher/Manager to identify that her responses to these cues were stimulated by contextual interpretive frames, and dispositional sense-making filters, through which she made sense of world. From time to time, the Manager was ‘struck’ by sudden events in her interorganisational context. These events challenged her sense-making and led to new appreciations and interpretations that contributed to her reconstructing her management routines. Sometimes these transformations were specific to one interorganisational relationship as in the Human Resources service when she decided to assume more leadership after a comment from a work colleague. On other occasions, the learning was transferable to another interorganisational relationship, as in her reflections after a comment by her Chief Executive that a less controlling approach to interorganisational relationship management could be beneficial.

The notion of contextual interpretive frames and dispositional sense-making filters has enabled the inclusion of ‘self’ as an influence in interorganisational relationship management. Through ‘self’ the sense-making manager interprets and enacts the construction of organisation. This finding extends the research about what behaviours contribute to successful implementation of interorganisational relationship strategies.

5.3.5.3 Personal Orientation: Summary

One finding to emerge in the research was the relatively elusive or perhaps benign influence of the Hospital’s not-for-profit status on the construction of the interorganisational relationships. The researcher had anticipated that the juxtaposition of not-for-profit and for-profit partners in the interorganisational relationships might have created more dysfunction. It emerged, however, that the opportunity for synergy was greatly dependent upon alignment of purpose through interpersonal relationship, and through complementarity, more so than fiscal structure. The not-for-profit Hospital also placed considerable emphasis on patient satisfaction as a measure of performance. In this regard the findings support the work of Hubbard (1997). However, it is possible that the not-for-profit status also contributed to construct a
financial imperative to deliver target margins through cost control of peripheral non-clinical support services. Thus, any prior assumption by the researcher that the not-for-profit and for-profit organisations would display different routines in relation to cost containment objectives, was found to require reinterpretation.

Three of the interorganisational relationships were dissolved because the Hospital ultimately decided the objectives of the relationship were not being met, and the quality of the service provision did not justify continuance. The decision to end these interorganisational relationships is consistent with existing research that says the interorganisational relationship strategy must enhance an organisation’s competitive performance. The outcomes for the interorganisational relationships in this research are, thus, consistent with this and with observations that more than fifty percent of interorganisational relationships fail (Linder et al, 2002; Harrigan 1985; Quinn 2000; Hutt et Al. 2000; Hitt et al. 2002). However, these business partners also participated in a sense-making process that was unable to construct interorganisational relationships that embodied the emotions, and the objectives, of the participating parties. While on a daily basis many ‘good’ things happened, interactions were insufficient to create adaptive sense-making and transformative behaviours that could create relationship longevity.

The near-core clinical support services interorganisational relationships in this research were described by a greater ‘depth’ of outsourcing (Gilley & Rasheed 2000). The suggested finding that these relationships were associated with perceptions of lower levels of client management activity has some parallel with findings from those researchers who suggested that ‘outsourcing was positively related to performance for innovative differentiators and negatively related to firms that were not pursuing innovative differentiation strategies’ (Gilley and Rasheed 2000, p. 785). While the current research does not draw conclusions about interorganisational relationship performance against objectives, there may be a parallel between level of client management involvement, interorganisational relationship functioning and interorganisational relationship longevity (as a measure of performance).

Gilley and Rasheed’s (2000) findings that peripheral outsourcing, with a cost leadership strategy, was positively related with firm performance were not clearly
supported in the current study. The Manager held a perception that the peripheral non-clinical support services interorganisational relationships struggled. This was not because they were necessarily inefficient. Rather it was because, in accomplishing this goal, they sacrificed longevity in the relationship.

The further finding of this research that near-core clinical support services can be outsourced and managed to achieve affective functioning is important. This is because most of the earlier research work about outsourcing and partnering has had its focus on low strategic value, ‘non-core services’ (Quinn 2000; Linder et al. 2002; Hunter & Healey 2002, 2003). This research finding suggests that organisations might take a strategic view about entering into interorganisational relationships that make them more interdependent. The outsourcing of higher value services such as pharmacy, diagnostic imaging services and pathology services, and the integration of such service providers into the core patient care processes of the Hospital, as in this research context, is consistent with these developments.

5.4 Chapter Summary

This chapter has extended the Manager’s interpretations in her narratives. It has revealed that there is much behind the daily explicit actions of managers involved in ‘looking after outsourced services’. Reflexive interpretation has revealed that contextual interpretive frames and dispositional sense-making filters affected the Manager’s sense-making during construction of six interorganisational relationships. This finding locates the Manager’s ‘self’ as a primary influence in interorganisational relationships functioning.

Over the period of the research the researcher/Manager came to sense that there were emotions embodied within her activities. With more reflexive interpretation she became aware that her sense-making was influenced by personal ‘ways of viewing’ and responding to her world. These realisations both challenged and disturbed her. From this discovery emerged the concept of the dispositional sense-making filter. This concept describes the lens through which the Manager made deeper and more meaningful sense of the contextual interpretive frames. Until this moment she was not sensitised to, nor fully appreciated, that deeper understandings about her actions
could be gained from a fuller appreciation of her ‘self’ as an influence in her sense-making process.

Managers and others develop psychological commitments and alignments to certain thinking that can shape organisational experiences (Velayutham & Perera 2004; Diefendorff & Gosserand 2003; Fineman 2003; Wright 2000). Management ‘biases’ that conflict with broader organisational goals, may result in aberrant or resistant behaviours with the potential to demolish interorganisational relationship construction. Collaborative responses that form interorganisational relationships call for adaptation of traditional line management routines. Constructing interorganisational relationships may best be interpreted as a dynamic, transformational management process.

In terms of the conceptualisations of Lasker et al. (2001), positive feelings could be linked to formation of synergistic interorganisational relationship functioning. Positive feelings advanced relationship functioning through perceptions of acceptable symmetry. Conversely, negative feelings undermined the collaborative process necessary to create synergy (Velayutham & Perera 2004; Diefendorff & Gosserand 2003). This research reveals how the dynamic nature of interorganisational relationship construction is both enriched, and diluted, by management activity.

In the final chapter, which follows, the conclusions about the research problem, implications for professional practice and suggestions for future research that flow from the dissertation are presented.
6 CONCLUSIONS

6.1 Introduction

It can be recalled that the main focus of this research is the management of inter-organisational relationships during the maintenance (construction) stage of implementation. Chapters 1 and 2 identified a relative paucity of research about the daily, collaborative management of these relationships. As identified in Chapter 1, it was the researcher’s professional experience of the difficulties in making such organisational structures work that led to this investigation. It was her management experience, which felt so complex and difficult, that led her explore why this was so. In the early stages of the enquiry it began to emerge that to focus only on management activity without taking into account the wider issues, such as those pertaining to the context in which she operated, would be too limiting. Interorganisational relationships are constructed by social interactions during which social actors apply tacit knowledge and construct new meanings. After recognising this, the research focus was sharpened to examine managers’ sense-making processes in interorganisational relationship management.

An interpretive research methodology enabled the researcher to come to a closer understanding of the Manager’s contribution to interorganisational relationship functioning. Inner and meaningful aspects of these social phenomena have been characterised through use of an auto-ethnographic-style. This approach has enabled an inherent flexibility to handle ‘thick description’ (Geertz 1973) for it is sympathetic to the iterative, interactive sense-making processes between managers and other stakeholders in interorganisational relationship functioning.

The management of interorganisational relationships has been examined from the viewpoint of the researcher as client Manager. The constructed narratives presented in Chapter 4 are the researcher’s reflective interpretations of her experience. They reveal the challenge presented to managers in their struggled to make sense of, and adapt, their traditional line accountability and management responses to the collaborative context. The picture gained of these management processes became more problematic as the different contexts of the interorganisational relationships
were revealed. Through using the reflexive interpretative process, the researcher/Manager has been enabled to construct ‘self’ knowledge that has contributed to her professional practice.

This chapter considers the conclusions from the research and presents recommendations in the form of a model for practitioners of interorganisational relationship management.

6.2 Conclusions about the Research Problem

The client manager view taken in this research has provided a useful perspective about interorganisational relationship phenomena. Operations managers are not always in the position to influence strategic decisions about interorganisational relationship strategies, nor to influence the choice of partner. They are responsible, however, to implement the decisions of others.

The research was about the management of interorganisational relationships. It was guided by three research questions: (1) How are interorganisational relationships managed at the Hospital? (2) How does management differ between interorganisational relationships at the Hospital? and, (3) What makes the management of one interorganisational relationship different from another at the Hospital? The research has shown that managers display a range of explicit activities when managing interorganisational relationships. Reflexive interpretation of a manager’s experience has revealed that explicit management displays (activities) belie a complex process of meaning construction that derives from, and contributes to further explicit management activity. This meaning construction evolves from the manager’s sense-making, stimulated by contextual events or cues that occur during the every day social interactions between participants within interorganisational relationships. These events as well as continuing social interactions create the context of interorganisational relationships, which have been conceptualised as processes rather than entities. Variations in the patterns of these events and social interactions between participants, contribute to make one interorganisational relationship differ from another at any time. The context of interorganisational relationship contributes to affect different sense-making by managers and distinctive functioning.
By focussing on the social, cognitive aspects of management activity, the research contributes to the field of sense-making. It does this in several ways. Firstly, it re-interprets daily management activity as an expression of a manager’s sense-making. It suggests that the aggregate of social interactions and their interpretation through sense-making, contribute to organisation forming. Through sense-making processes knowledge that is construction becomes embedded in new management practices and participant behaviours that in time construct the institutionalised norms and standards of behaviours the construct the ‘distinguishable’ interorganisational relationship. Secondly, through the reflexive interpretive process the researcher has gone ‘inside’ the manager’s ‘lived experience’ to identify and associate two key cognitive structures that influence managers’ sense-making. These are the contextual interpretive frames and dispositional sense-making filters through which managers make sense of cues in their collaborative context. The interplay of these frames, filters and cues captures, and contributes, to variations in the functioning of interorganisational relationships.

The findings in this research confirm the complex process of delivering services and managing in an interorganisational relationship context. This complexity helps to describe why it can be difficult to manage interorganisational relationships for effective functioning. The state of ‘effective functioning’ has been defined as the synergy that may be achieved in a dynamic collaborative business structure (Gray 1989; Fried & Rundall 1994; Lasker et al. 2001; Richardson & Allegrante 2000). Interorganisational relationship managers have responsibility not only to deliver the contracted product or service but also to deliver the collaborative relationship that achieves longevity. This research has shown that in practice this does not always happen. There is a gap between the business transactions of interorganisational relationships and the complex ‘lived realities’ of organisational life.

Through an interpretative analysis this research has identified a number of contextual influences that affect the functioning of interorganisational relationships in a Hospital setting. The exploration contributes to understanding management as a sense-making process in which managers’ tacit knowledge structures and their embodiment in the ‘self’ influences interorganisational relationships construction. Strengthening of this awareness will be helpful to practising managers.
Managers of interorganisational relationships are in the position to construct, or deconstruct, interorganisational relationships. The collaborative context is different to the one in which traditional line management processes are used, despite the fact that the routines appear to be similar. In the collaborative context, the routines are derived and undertaken in a shared way (Useem & Harder 2000). Managers in this research quite often perceived their management role as a struggle. They sensed that they were in unfamiliar territory and expressed this with various expressions such as, a ‘loss of control’ and ‘there is no leadership’. This perception was constructed, through interpretive frames, and from experience gained in contexts where they had autonomy and authority to assume ‘complete’ responsibility for the actions and outcomes of their decision making. This view of management ‘reality’ was revealed in the Manager’s narratives, as well as in interviews with other client managers involved in the Hospital’s interorganisational relationships.

Making and influencing decisions in a collaborative context have been shown to be repetitive and protracted. The decision-making process involves negotiation and compromise which can generate feelings such as uncertainty and frustration. Managers consciously ‘engage’ with the relationships to ensure that mutual benefits are achieved. Without client participation the service provision is more akin to procurement and the form of the relationship can fail to achieve the synergy that delivers transformation.

Managers of interorganisational relationships assume a responsibility to institutionalise new organisational behaviours and give rise to new capabilities in the organisation. In this respect managers of interorganisational relationships manage significant change within organisations wherein, simultaneously, the traditional forms of management may persist for other services. The interorganisational relationship context stimulates a sense-making process that ‘sifts’ out those institutionalised routines that still apply, and creates new ones that require a different set of rules to govern collaboration. This situation sets up a tension with the rules that have traditionally governed the social systems in which they work. Employees and managers draw on these rules in producing and reproducing the social actions that govern the work they do and the systems they create. Frustrations arise when the ‘appropriate’ rules are not learned and applied in the different contexts.
The sense-making approach highlights management as a transformative process in which new routines enable the interorganisational relationship to emerge. When these new knowledge structures are slow to emerge, tensions and struggles may ‘damage’ the potential of the interorganisational relationship.

The conclusions from this research emphasise the emergent, dynamic nature, of interorganisational relationships in their maintenance phase. Managers have a guiding influence on constructing interorganisational relationships. This influence may be persuaded by key capabilities that will be important for practicing managers:

1. Adopting adaptive and constructive behaviours that enable the inter-subjective structures of the organisation to develop the mutual benefits of collaboration.
2. Recognising that residual competency in the client may present as a ‘risk’ to synergistic functioning in interorganisational relationships so that an appropriate balance is best constructed to achieve partnership complementarity.
3. Actively participating in the construction of \emph{qua persona} relationships between stakeholders and balancing these with relationship formalities such as contract monitoring.
4. Becoming an agent for the client organisation and interorganisational relationship.
5. Awareness that contextual interpretive frames and dispositional sense-making filters contribute to construct a manager’s ‘self’ and affect ‘reality’ construction in silent or subtle ways.
6. Appreciation of ‘self’ in relation to others in the organisation.
7. Providing transformational leadership.

Interorganisational relationship managers shape new systems and structures. Parties in the relationship will respect that a process of adaptation will transform the interorganisational relationship through time. The interorganisational relationship manager’s task is to manage a continuous process of transformation that evolves the relationship.
The research problem was formulated from professional practice experience in a not-for-profit health care organisation. The research has shown that interorganisational relationships can be managed in these business environments. In this regard they do differ from the commercial sector. The only discernable aspect of the culture in the not-for-profit business environment that has impacted management activity was the emphasis on quality of service relating to client and patient satisfaction. In the absence of a financial emphasis (shareholder value) as the primary business goal, the drive for service redesign and client satisfaction resulted in additional management activity. The next section summarises the contributions of this research.

6.3 Contributions of the Research

Relating the findings of this research to other research findings is problematic because of the wide variation in meaning of the interorganisational relationship construct. Notwithstanding this, much research about interorganisational relationships relates to delivery of non-core services. It is argued that outsourcing non-core activity enables greater focus on resources for an organisation’s core activities. In this respect the findings from the current research extend understandings about partnering for near-core business activities.

This research contributes to understanding about the management processes for clients in interorganisational relationships. There is a wide gap in the empirical research about the process of managing in these collaborative contexts at the organisation level. Much of the focus is about the strategic decision to partner in service delivery (Lei & Hitt 1995; Gulati 1998; Das & Teng 2000; Hodge 2000). If it is not about the benefits of this strategy, then it is about the performance outcomes of the decision (Harrigan 1985; Hutt et al. 2000; Quinn 2000; Hitt et al. 2002). More recently researchers have begun to conceptualise and measure resources flows between organisations in relationships (Kraatz 1998; Yli-Renko et al. 2001; Hitt et al. 2002) and some researchers have begun to consider social capital formation (Ring & Van de Ven 1992; Gulati & Singh 1998; Gulati 1995a, 1995b; Chikudate 1999a, 1999b; Stuart 2000) and the application of sense-making processes to organisation change (Weick 1979, 1993, 1995, 1999; Chikudate 1999a, 1999b; Dutton et al. 2001; Maitlis 2005). Organisations that have the capability to work within
interorganisational relationship structures are said to possess competitive advantage in the market (Mockler 1997; Das & Teng 2000). This research contributes a perspective on one aspect of social capital by examining how management processes construct interorganisational relationships. In this regard the research contributes new knowledge about the construction of social capital.

Early research literature about interorganisational relationships (alliances) reports empirical work from the manufacturing industry sector (Quinn & Hilmer 1995; Dyer 1997; Gulati 1998; Osborn 1998; Wakeman 2000) and the information technology industry (Loh & Venkatraman 1992; Lacity & Hirschheim 1993). Most of the research work is about non-core relationship functioning. The finding that near-core clinical support services appear able to be successfully delivered through an interorganisational relationship process is important.

While there is some health sector research that is particularly focussed on community health networks (Butterfoss, Goodman & Wandersman 1996; Wandersman, Goodman & Butterfoss 1997; Lasker et al. 2001; Lasker & Weiss 2003) and on public sector relationship management (Hunter & Healy 2002, 2003; Hodge 2000), there is less empirical work from the private not-for-profit health hospital sector. This research is about a private not-for-profit health organisation that has adopted a business strategy normally associated with the for-profit sector. The findings, therefore, contribute to the wider body of work by suggesting that interorganisational relationship strategies have application across industry sectors.

The further significant contribution of this research is in its use of a reflexive interpretive methodology and an auto-ethnographic style to explore business phenomena that is projected to grow internationally. The research approach has enabled sensitive material to be explored in the process of exploring how new knowledge is created. The application of sense-making constructs has enabled the researcher to explore the inner interpretive processes of a manager grappling with daily responsibilities and accountabilities. While the findings in this research present one view of ‘reality’, other managers of interorganisational relationships may recognise, and be ‘struck’ by, similar situations and contexts. Such engagement with
the research findings will contribute to further reflexive practice by others and extend the contribution of this research.

The following section comments on the implications of this research.

6.4 Implications of the Research

This research has implications management practice and theory. Each of these areas is discussed separately in the following sections.

6.4.1 Implications for Management Practice

The exploration of the management of six interorganisational relationships at the Hospital, and the management routines implemented by the Manager, offers one perspective on interorganisational relationship functioning. Practicing interorganisational relationship managers acknowledge that interorganisational relationships may be difficult to implement and researchers have observed that interorganisational relationship have high failure rates (Hutt et al. 2000; Quinn 2000; Hitt et al. 2002). A better understanding about the role of managers who implement these business strategies may contribute to more effective interorganisational relationship functioning and longevity.

In this research it has been suggested that there are contextual influences in the interorganisational relationship context that affect interorganisational relationship managers’ behaviours. The interorganisational relationship context makes collaborative management processes essential to achieving effective functioning. Collaboration is a process through which parties constructively search for solutions that go beyond their own limited vision of what is possible to resolve their differences (Gray 1989). Collaboration requires procedures and structures that may be different from the traditional ways many people and organisations have worked (Lasker et al. 2001). Lasker et al. (2001) build on the work of others to conceptualise a collaborative framework based on synergy, leadership and the social ties between participants. They define synergy as the power to combine the perspectives, resources, and the skills of a group of people and organisations, to achieve advantage
Interorganisational relationships involve time because relationships result from an iterative process of interdependent actions between the members (Van de Ven 1976; Boddy et al. 2000). Managing over time may be difficult by virtue of the diversity and dynamism (Wandersman et al. 1997) that is involved. Interactions between interorganisational relationship members transform the operational context. A manager’s task will be to guide these transformational interactions (Hunter & Healy 2002, 2003; Linder et al. 2001).

The concepts of sense-making and transformation are presented in a model of transformational interorganisational relationship management. The model provides a conceptual framework that managers can use to build sustainable interorganisational relationships.

6.4.1.1 Model of Transformational Interorganisational Relationship Management

Interorganisational relationship leaders and managers will understand that relationship longevity stems from flexibility, acceptance of diversity (the complementary nature of relationship), and adaptive behaviours. By engaging in interorganisational relationship management as a dynamic process the true objective in the decision to partner may be realised. Active relationship management will transform the interorganisational relationship so that it meets the ongoing needs of the interorganisational relationship members.

Figures 6-1 to 6-4 models show how this might work. The attributes of the process are briefly described for each stage illustrated.
The strategic decision to adopt an interorganisational relationship strategy is often made within a setting that is characterised by institutionalised management practices. Figure 6-1 represents this situation in which culture forms gradually and change is incremental. Service delivery initiatives are taken and over time converted to routine practices as stakeholders engage with change. Improvement in organisational performance is slow. The organisation considers a business relationship strategy to leverage business competitiveness. Figure 6-2 represents events soon after the decision to co-operate with an external organisation in the process of service delivery.
Adopting the interorganisational relationship strategy represents a significant change. The value learning cell represents sense-making behaviours, stimulated by the new context, the process of reinterpretation, and the introduction of new practice. Managing this change moves operational practice beyond institutionalised behaviours into new routines. Value learning cells represent the sense-making and the knowledge construction that precedes new management behaviours, such as contract management, relationship forming and stewardship rather than control. This is adaptive change. Synergy will emerge through the process of combining the multiple perspectives, resources and capabilities of the partners. Interorganisational relationship managers redevelop behavioural norms and joint service delivery practices. Co-operation and collaboration emerges from new joint understandings.

At this stage there is scope to develop metrics to monitor and manage progress towards agreed goals. Metrics describe practices that are institutionalised by time as well as the progress of new objectives in value learning cells. Furthermore, social ties
contribute to stakeholders’ perceptions about synergy and functioning of the interorganisational relationship itself.

Figure 6-3 represents a stage of greater maturity where new behaviours have commenced to become embedded as routine practices. Relationships have been established. The results of collaboration are becoming evident.

**Figure 6-3 Model of Transformational Interorganisational Relationship Management: Stage 3**

The Line of Transformation represents the path of the interorganisational relationship towards greater synergy and goal achievement. It represents the emergence of the relationship over time. As the relationship is managed interorganisational relationship behaviours are endorsed and institutionalised. Synergy creates expectations about continuing opportunities from the relationship. As structures and resources are deployed in this expectation, new systems of practices become routines. The Threshold of Practice extends along the Line of Transformation as interorganisational relationship synergy grows.
Potential Practice Change represents the opportunity for improved functioning of the interorganisational relationship. The interorganisational relationship managers work with one another to scope out the direction of this change and to manage the relationship so as to leverage the organisations along the Line of Transformation.

Evaluating the quality of the relationship through a social audit also monitors the strength of social ties and networks associated with the interorganisational relationships and highlights their significant contribution to relationship functioning. The assessment of positive relationship functioning will measure the level of synergy. The level of synergy will represent a measure of the advantage in dyadic relationship over single entity operations.

Figure 6-4 shows what happens over time and the further potential for value growth.

**Figure 6-4 Model of Transformational Interorganisational Relationship Management: Stage 4**

Source: Developed for this research
Value learning cells continue to emerge and the synergy of relationship grows. The interorganisational relationship is integrated within the normal operations and service outcomes of the partners. Interactions are monitored in terms of the benefit of collaboration. The institutionalisation of new management practices continues.

The Threshold of Practice represents the absorptive capacity of the organisation as new behaviours are institutionalised. This adaptation also represents the development of social capital through the construction of new knowledge, expressed in new competencies that enhance the competitiveness of the partnering organisations. The emergence of the interorganisational relationships continues is represented by the ‘movement’ along the Line of Transformation as in Figure 6-4. Synergies create the business environment wherein the participating organisations achieve mutual benefit. New behaviours become embedded and the organisations transform. The process of transformation continues for as long as the interorganisational relationship business strategy is appropriate.

Operationalising this model will require organisational competencies. Relationships require leadership and management. Participants need to be ‘engaged’ with the relationship and to share a multi-perspective approach (Linder et al. 2002; Useem & Harder 2000; Lasker et al. 2001). Building interorganisational relationships is a challenge for organisations and managers. ‘Partnerships … need boundary spanning leaders who understand and appreciate partners’ different perspectives, can bridge their diverse cultures, and are comfortable sharing ideas, resources, and power’ (Lasker et al. 2001, p. 193).

6.4.2 Implications for Theory

The research about interorganisational relationships is varied and comes from a wide range of disciplines that contribute a different perspective on the interorganisational relationship phenomena. This research suggests that interorganisational relationships can be successful in service industry contexts where the perception of ‘value’ by clients and customers extends beyond the attributes of a product, but into the qualitative ‘experience’ of the service process as well.
The interpretive theoretical perspective provides a legitimate and valuable approach to construct new knowledge about the daily impacts of those actors involved in making interorganisational relationships work. This approach contrasts with the positivist approaches that characterise much of the literature in the field and which, as a consequence, tend towards predictive conclusions. Interpretive narratives are relevant to the analysis of organisational processes, like managers’ sense-making processes, because narratives represent social enactment derived from embedded structures within organisational cultures. Narratives offer abstract conceptual models used in explanations of observations (Pentland 1999) and contribute to theory building by providing the basis for continuing explanation.

The narrative voice in this research is that of a senior manager, told from the viewpoint of the client in the interorganisational relationship context. Other voices are threaded through the narratives such as the researcher and other managers. These voices are interwoven when actors tell of their perspectives and reflections, and as they enact the process of interorganisational relationship formation.

The researcher has been particularly influenced by the work of Weick (1979, 1993, 1995), Chikudate (1999a, 1999b) and Ring & Van de Ven (1992, 1994) in the exploration of the impact of changes in context on the sense-making process. This research also suggests that in any context the management process, and the response of actors, is far from linear or predictive. It is much more dynamic and ad hoc, complex and contextual. It also appears that the interplay of contextual influences and contextual interpretive frames which affect managers’ sense-making and behaviours, may also impact on both the intended and unintended outcomes of interorganisational relationships. In particular the suggestion that contextual influences stimulate managers contextual interpretive frames as they make sense of the collaborative context, provides an appreciation of the impact of ‘self’ as an influence in interorganisational relationship functioning. The notion that filters add more, or less, influence in management processes, further highlights how important managers’ competencies are in creating effective interorganisational relationship functioning.
Research using social network theoretical frameworks may be usefully adopted to further investigate the role of emotions as critical triggers/pointers of interorganisational relationship functioning. These findings extend the existing research by exploring the social behaviours inherent in the transactions in the positivist cost economic theory. Sense-making and knowledge construction have emerged as important aspects in interorganisational relationship functioning. The study of social interactions represents a rich framework for investigating the constructive and destructive (Weick 1993) effects of managers’ decision making in the dynamic emergence of an organisation’s social capital. Finding a way to adequately measure and manage this social asset will extend the concept of interorganisational relationship performance.

The research uses an interpretive approach to investigate one aspect of the interorganisational relationship business strategy. This approach contrasts with existing conceptual and empirical investigations from the manufacturing and electronics area. It is effective at the local level where understandings about behaviours and their impacts on organisational functioning are necessary learning for practicing managers. Interpretive studies enable a richness and depth in the empirical materials that is not always available through the positivist approach. Further, such methodological approaches portray ‘real life’ experiences for other interorganisational relationship managers in ways that may ‘strike’ accord with their life experiences.

This research also lends support to Chikudate’s (1999a, 1999b) call, supported by Cunliffe (2002) in the context of management training, for there to be greater use of reflection and reflexivity in managers’ approach to their field. Reflective/reflexive processes have contributed to improved understandings for this researcher. This new knowledge has been used in subsequent interorganisational relationship experiences and shared with other managers and consultants.

### 6.5 Further Research

Findings in this research are indicative and generalisations have not been made. Transferability to other contexts rest with the reader. The research examined interorganisational relationships within one organisational setting using a auto-
ethnographic style. This has given focus to the management experience of one senior manager as she managed the construction of six interorganisational relationships over an extended period of time. Comparison of the different interorganisational relationships demonstrates the usefulness of the interpretive approach in diverse contexts for it enables explication of themes across the interorganisational relationship phenomena.

The perspective presented is that of the client Manager in the interorganisational relationship. The findings, therefore, present one view of collaborative relationship management. The intention has not been to explore the juxtaposition of the parties in the relationship, but rather to focus on the client management processes within the collaborative context. Participant observation and auto-ethnography has given a depth to the study and the researcher has taken some risks in reflecting upon personal experiences. She has exposed her feelings and reflexively identified her predisposition to think in particular ways. The interpretive approach utilises these biases to add richness to the findings and the reader is invited to make personal reflections about the empirical materials, such as the narratives, and to accept, or reinterpret, the researcher’s view. This process of reflection and interpretation will enable new findings to emerge as the reader brings his/her own experience into the account.

The findings highlight the challenges for managers in long term collaborative contexts in both to the hierarchical and the horizontal constituencies. The research extends observations by others that interorganisational relationships are difficult and hard to implement. Further research into the management behaviours that enable relationship building and joint decision making will support practicing managers. Traditional line management approaches characterise business school teaching; more research on collaborative behaviours and relationship management is required. Social interaction and reflexivity will offer relevant theoretical frameworks for these explorations and build meaning about the iterative and transformational nature of sustained collaborative business contexts.

Future research may investigate the management of interorganisational relationships using an integrative approach. This would enable the researcher to examine how
clients and services providers jointly, or simultaneously, make sense of contextual cues in their shared collaborative contexts. This approach will enable more insights into the social interactive process as ‘multiple selves’ deliver activities and construct routines. Further studies may seek deeper understanding about the contribution of managers’ personality, experience and competencies, and explicate deeper associations between the ‘self’ and context as a key influence on interorganisational relationship functioning. A pointer was also made to the influence of gender in the construction of contextual interpretive frames and dispositional sense-making filters. This may be an area for further exploration.

It would also be worthwhile to investigate the effect of different business objectives on interorganisational relationship management activity. There was evidence in the current research that the interorganisational relationship based on learning and knowledge transfer achieved functioning through higher levels of social interaction. Conversely, for those interorganisational relationships where there was less management intensity, functioning was also perceived to be effective. Further research in this area will assist to understand the impact of strategy on management activity. Another area for further research concerns the question of a manager’s sense-making contribution in the context of perceived residual competencies. There has been a suggestion in this research that the structuring of business partnerships is important in manager’s sense-making. As well, there is a question about the maintenance of synergistic functioning in an interorganisational relationship. Research could explore how managers’ sense-making changes over time and is affected by familiarity with the provider’s services and what associations might emerge between this state of familiarity and continued construction of the interorganisational relationship.

This research represents an initial attempt to understand how the interorganisational relationship context affects management activity. The interpretive analysis suggests that a manager’s sense-making can have both positive and potentially negative affects on the effectiveness of interorganisational relationship functioning.
6.6 A Final Note

Managing interorganisational relationships for the longer-term benefit of the partnering organisations requires a management capability, combined with support and preparedness that enables the interorganisational relationship to evolve and transform. This will require the partners to be responsive and adaptive to emerging needs and to shed the short term controlling approach that is inherent in traditional contract enforcement techniques. Managers of interorganisational relationships need to accept a transformative approach and develop stewardship strategies that anticipate and respond to changing client perceptions and measures of value outcomes. Both provider and client need to work in a synergistic way to create an interorganisational relationship that is dynamic.
APPENDICES

7 Appendices
Appendix 1  INTERVIEW PROTOCOL

Outsourcing at the Hospital

The following questions will form the basis of interviews with selected manager stakeholders.

1. What is your particular role with interorganisational relationships at the Hospital?
2. With which providers do you have the service relationship?
3. How would you describe your service relationship with these providers? (Take one at a time if there is more than one).
4. What are the specific tasks or activities you undertake as a manager with this provider?
   (Show a list of possible types of management activities to use as a prompt. The respondent may want to highlight those on the list. The response to this question will guide the subsequent questions)
5. Taking this particular activity (from 4)
6. Can you describe for me how you became involved in this activity and what happens?
7. How often do you become involved in this activity?
8. What factors do you think contribute to your involvement in this way?
9. How do you compare your activity with this service provider and the others you associate with?
10. Why do you think there are these differences?
11. How do you think Providers should be managed?
12. What would you like to see happen?
Functioning and Management Sense-making Routines

Thinking about your own involvement with the interorganisational relationship, how often did you get involved in the following activity?

1. Not at all
2. To a minimal extent
3. To a small extent
4. To a moderate extent
5. To a significant extent
6. To a great extent
7. To a very great extent

Limiting expenditure 1 2 3 4 5 6 7
External auditing 1 2 3 4 5 6 7
Withholding support 1 2 3 4 5 6 7
Informal discussions about personal matters 1 2 3 4 5 6 7
Lunches together 1 2 3 4 5 6 7
Entertainment and functions 1 2 3 4 5 6 7
Corridor conversations 1 2 3 4 5 6 7
Meetings with friends or colleagues of the provider 1 2 3 4 5 6 7
Friendship with provider’s staff 1 2 3 4 5 6 7
Drop-in conversations with the providers superiors 1 2 3 4 5 6 7
Introductions to business colleagues of the provider 1 2 3 4 5 6 7
Use of the provider’s network of business contacts 1 2 3 4 5 6 7
Walk the talk sessions with the provider on the floor 1 2 3 4 5 6 7
Visits to the providers business environment 1 2 3 4 5 6 7
Discussions about business objectives – to define them 1 2 3 4 5 6 7
Discussions about business objectives – to align them 1 2 3 4 5 6 7
Discussions to problem resolve 1 2 3 4 5 6 7
Disciplining the provider 1 2 3 4 5 6 7
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Auditing the provider’s services
Explaining the provider relationship to others in the Hospital
Responding to complaints about the provider from joint customers
Giving the provider feedback
Involving the provider in strategy planning for the Hospital
Managing provider access to information
Going over the site managers to higher management in the provider organisation
Explaining the providers authority
Appointing key personnel
Buying equipment for the provider
Establishing operating procedures
Meeting with providers stakeholders
Smoothing the waters
Looking for ways to improve functioning of the interorganisational relationship
Providing strategic information to the provider
Providing technical information to the provider
Seeking legal advice relating to the relationship
Legal communication exchange with the provider
Repairing “damage”
Changing the terms of engagement
Evaluating the providers performance
Mentoring the provider
Fulfilling promises to the provider
Seeking new commitments from the provider
Talking about the provider to others
Seeking advice from others about the provider’s performance (benchmarking)
Compromising practices because of the provider
Delaying decision relating to timeliness problems
Discussing relationship issues
Listening to the providers concerns
Allocating resources to the relationship
Attempting to find out what somebody else has done/determined relating to the relationship
Discussing the relationships future with others
Marketing the relationship within the organisation
Justifying the partner’s decisions
Measuring the customer satisfaction
Managing inter-firm relations
Evaluating if the provider relationship is meeting Hospital objectives
Supporting hospital stakeholders impacted by the service provider
Protecting intellectual property
Checking financial performance
Aligning objectives
Aligning cultures
Discussing operating norms, standards for the relationship
Describing expectations
Participating in providers decisions
Checking customers for feedback  1  2  3  4  5  6  7
Team building  1  2  3  4  5  6  7
Supporting provider personnel  1  2  3  4  5  6  7
Responding to provider’s requests for help  1  2  3  4  5  6  7
Guiding problem resolution  1  2  3  4  5  6  7
Clarifying authorities  1  2  3  4  5  6  7
Helping resolve problems  1  2  3  4  5  6  7
Fixing fall out or consequences  1  2  3  4  5  6  7
Solving cooperation-related problems  1  2  3  4  5  6  7
Listening to ideas and suggestions from the provider  1  2  3  4  5  6  7
Implementing ideas from the provider  1  2  3  4  5  6  7
## Appendix 2  THE MANAGER’S ROUTINES

### Table 2.1 Manager’s Perceived Level of Involvement in Interorganisational Relationship Construction

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**Key:**  
1  no involvement  
2  minimal involvement  
3  small involvement  
4  moderate involvement  
5  significant involvement  
6  great involvement  
7  very great involvement  
IOR  interorganisational relationship
### Routines by Interpretive Frames and Sense-making Filters

#### 3. Trust

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**Key:**

1. no involvement
2. minimal involvement
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IOR **interorganisational relationship**
5. My view

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**Key:**

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IOR  interorganisational relationship

*Source: Developed for this research*
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