A middle manager's response to strategic directives on integrated care in an NHS organisation: Developing a different way of thinking about prejudice

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Abstract

Key words: National Health Service (NHS), Department of Health (DH), integrated care organisation (ICO), strategic directives, integrated care, communicative interaction, systems approaches, organisational change, resistance, prejudice, reflection, reflexivity, complex responsive processes.

Key authors: F. Dalal, N. Elias, M. Foucault, G.H. Gadamer, G.H. Mead, I. Prigogine, E. Schein, J.C. Scott, P. Senge, R.D. Stacey.

This thesis examines a middle manager's response to strategic directives on integrated care in a National Health Service (NHS) organisation and the development of an awareness of prejudice that acknowledges its relationship to the process of understanding. The research focuses on an integration of two community NHS trusts and an NHS hospital trust into one integrated care organisation (ICO). A change programme was initiated and promulgated on an assumption that integrating the three organisations would facilitate integrated care. However, despite the use of organisational change approaches (such as communication plans and systematic approaches to staff engagement), implementing the strategy directives in practice remained problematic. What emerged during the integration process was resistance to change and a clear division in the different ways of

working in the community NHS trusts versus the community and hospital trusts – differences that became apparent from the prejudices of individuals and staff groups.

The proposition is that prejudice is an important aspect of relationships whose significance in processes of change is often overlooked. I argue that prejudice is a phenomenon that emerges in the processes of particularisation, which I describe as an ongoing exploration and negotiation in our day-to-day activities of relating to one another. Our pejorative understanding of the term 'prejudice' has overshadowed more subtle connotations, which I propose are unhelpful in understanding change in organisations. However, I suggest a different way of thinking about prejudice – namely as a process that should be acknowledged as a characteristic of human beings relating to one another, which has the potential to generate and enhance understanding.

The research is a narrative-based inquiry and describes critical incidents during the integration process of the three organisations and focusing on interactions between key staff members within the organisation. In paying attention to our ongoing relationships, there has been a growing awareness of disconnection from traditional management practices, which advocate systematic approaches and staff engagement techniques that are designed to encourage cooperation and reduce resistance to proposed change. This thesis challenges assumptions surrounding prejudice and how middle

managers traditionally manage organisational change in practice in their attempts to apply deterministic approaches (which assume a linear causality) to control and influence human behaviour. I have taken into consideration a hermeneutic perspective on prejudice, drawing on the work of Hans Georg Gadamer, and have argued from the viewpoint of the theory of complex responsive processes. This offers an alternative way of thinking about management as social processes that are emergent in our daily interactions with one another, that are not based on linear causality, or on locating leadership and management with individuals. It provides a way of taking seriously the relationships between individuals by paying attention to what emerges from the interplay of our expectations and intentions.

This leads to a different way of thinking about the relationship between prejudice and strategic directives, which I argue are not fixed instructions but unpredictable articulations of our gestures and responses that emanate from social interaction and continually iterate our thinking over time. This paradoxically influences how we make generalisations and particularise them in reflecting on and revising our expectation of meaning I suggest that it is not possible to predetermine a strategic outcome; and that traditional management practice, which locates change with individuals – and reduces aspects of organisational life, such as resistance, into a problem to be fixed – obscures our capacity to understand the processes of organisational change in the context of a much wider social phenomenon. I

therefore conclude that my original and significant contribution to the theory of complex responsive processes and to practice is encouraging a different way of thinking about prejudice – as a process that can be productive and generate understanding, when considered as encompassing our expectations of meaning, linked to our own self-interests. This then opens up possibilities for transforming ourselves in relation to others – and, through this process, to transform the organisations in which we work.

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Introduction

The context

This research takes place within three NHS organisations – two neighbouring community NHS trusts and a hospital trust – as they merge over three years into an integrated care organisation (ICO), thus combining three parties that would previously have viewed each other as competitors in the health economy. The thesis charts my journey as a middle manager (with a history of working in community health provision), with the responsibility of implementing change during and after the integration, and the difficulties I experienced in trying to restructure clinical services while also trying to encourage staff from these three very different organisations to work together cohesively. At the heart of these changes was a need to provide more efficient and productive health care to patients. From a government perspective, this meant reducing 'unnecessary' hospital care and providing more care in the community. At a local level, this required the executive team to remove all previous organisational boundaries. The directive to restructure resulted from the new executive team deciding that to achieve integrated working, clinical teams should start sharing clinical practice. It was believed that the best way to encourage such collaboration was through developing clinical care pathways for patients. However, given that the organisational cultures were completely different, we found it extremely difficult to alter our working practices, or to explore any changes

with each other through ‘stakeholder’ meetings, because we perceived change as threatening to our identities. This led to many situations of conflict, triggered by what I now see as prejudice and culminating in resistance to change.

Middle managers like myself clung to organisational policies and strategic directives in the hope that, during times of such change and uncertainty, stringency in procedures and processes would provide coherence and consistency around communication. Our plans, with their pre-determined outcomes, would enable staff to have something concrete to work towards and provide a sense of stability. These were my assumptions at the time, having lived through many organisational changes and being used to relying on strong leadership to provide direction and control situations. As the integration progressed, I began to realise that traditional management approaches to change did not seem to provide a solution to the problem of implementing strategic directives and reducing conflict and resistance.

My argument

I present a different perspective, using the theory of complex responsive processes to demonstrate that strategic directives, articulated as a set of rules or instructions, have emerged from our experience of immersing, abstracting, participating and reflecting in local interactions. Our responses to these emerging directives change, depending on how we interpret and

particularise them, which I argue is a process of exploration and negotiation and a part of human interaction that is a social phenomenon. I also propose that we cannot continue to think of managers as autonomous individuals who can objectively stand outside the process of change, because this reduces and problematises facets of organisational life that are inevitable through our interactions with others.

From a traditional management approach, the facet of organisational life that we typically try to reduce in organisational change is resistance. I demonstrate in my research that at the heart of resistance is prejudice. I present an alternative perspective from its pejorative association, to argue that it is an embodiment of our expectations of meaning and linked to our own self-interests, acknowledging its significance in the process of understanding.

A voyage through my projects is an excursion into the method

This thesis is not structured as a conventional research project. There are four projects, each developed around a narrative of critical incidents that occurred during and after the formation of the ICO. I explored my experiences at the time and interpreted them drawing on the works of specific authors writing in the field of psychology, sociology and philosophy. Although the narratives were important in my exploration of a particular problem, the focus of my inquiry into my experiences became the ability to question and re-examine my thoughts from the past in light of

present circumstances and new understanding. Although the projects were successively reiterated at the time, I have not rewritten anything retrospectively: to do so would have not allowed the reader to see the movement of my thinking in the production of knowledge and understanding. In the detail and quality of the writing, what slowly emerges and evolves is how my experiences change as I begin to pay more attention to behaviour resulting from interactions that would otherwise be overlooked or considered inconsequential. Content and context have been scrutinised, and subjectivity taken seriously, when considering how others and I are interacting in our relationships with one another.

In Project 1, I explore my earliest recollections of coming into the NHS and progressing as a middle manager. I examine my traditions and start to piece together problems that have arisen in thinking about my previous assumptions about the role of a manager and ways that I have been used to managing change.

In Project 2, I focus on a difficult time in my life where I face a dilemma in making decisions that affect a staff member who was both a colleague and a friend. I begin to question the difficulties of implementing strategic directives within a traditional communication model, and also start to provide an alternative way of considering organisations through the theory of complex responsive processes.

Project 3 raises the issue of the experience of difference, and my acceptance of traditional management approaches to communication and planned meetings that attempt to control change and manage resistance. However, discovering that these approaches do not work, I start to examine another way of thinking about resistance – understanding this as a social, rather than individual, phenomenon.

Project 4 has been the most poignant for me. Following Project 3, I was all set to further explore the idea of resistance; but in Project 4, I soon became aware that at the heart of my problems with staff was not resistance, but the issue surrounding prejudice. Project 4 becomes a tussle in my thinking as I start to consider the ideas of paradox and my experiences of both internal and external conflict, in trying to acknowledge prejudice – not only in its pejorative sense, but also as a process to understanding as seen from a hermeneutic perspective.

Lastly, I present the synopsis and critical appraisal as my final thoughts for this thesis and my broader contribution to knowledge and practice. This in turn provides a framework for considering the theory of complex responsive processes from a methodological viewpoint: developing this generative capacity to understanding in the ways I think and continue to rethink my narratives.

I believe that this thesis demonstrates how meaning and understanding emerge from social interaction – not only engagement with

the scenarios described, but also the ways I have gone about writing and analysing my thoughts – a process that is not confined to interactions with my colleagues at work, fellow students on the DMan programme, or my supervisors, but also includes the way others and I interact with the text itself. So I invite the reader to engage with the narrative and see what possibilities emerge.

Project 1

A historical account of my journey into middle management: Balancing traditions

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The invisible dietitian

I would describe myself as first-generation Hong Kong Chinese. My parents came to England in the 1960s to study for their vocational careers. They met and married in the UK. My father was a lawyer, my mother a nurse in the National Health Service (NHS). Culturally, they instilled a work ethic within me that included having aspirations around my career choices. In those days, most of my parents' friends' children were pushed into healthcare professions; it was considered particularly prestigious to have a career as a doctor. Unfortunately, I was not academic enough to pursue a medical career. My decision to become a dietitian was both to satisfy my mother's desire to see me choose a healthcare profession and because the NHS was seen as a safe and dependable job. So I chose a career in dietetics, in the hope that this would somehow compensate for not having gone to medical school.

My NHS dietetic career began in 1991 following a two-year postgraduate diploma in dietetics, from Leeds University. The decision to pursue a career in dietetics followed on from my first degree in health

sciences: a modular degree comprising biochemistry, physiology and molecular biology. It was during my physiology module that we had a section on nutrition, which fascinated me. Food plays a fundamental role in Chinese culture. My parents had always emphasised the importance and significance of certain foods, not just for their health-giving properties, but also for their medicinal and spiritual aspects. Food, in balancing *chi* – the 'life force' or 'life essence' – is essential for well-being. The Chinese belief that life is a dynamic process of apparently opposing, yet complementary, energies seeking balance is a key tenet of Taoism (a religion that has existed for some 2000 years, originating from many ancient philosophical traditions). Illness was considered an imbalance of those energies. To my family, food was fundamental to life; in my younger years, I never questioned these beliefs because Chinese and Western medicine always had a close relationship in our home.

My interest was sparked when I began to learn just how many diseases could be managed through dietary manipulation. Though I had grown up understanding this, I was now intrigued by the scientific possibilities and decided that I would research careers involving nutrition. Two roles automatically sprang to mind: nutritionist, or dietitian. Nutrition is the study of how the body uses nutrients, and the relationship between diet, health and disease. Dietetics is the interpretation and communication of the science of nutrition to enable people to make informed and practical

choices about food and lifestyle, in both health and disease. A dietitian will have trained in both hospital and community settings as part of their course; most dietetic careers available to me were within the NHS (NHS Careers, 2010).

In 1991, I became a registered dietitian with the Health Professions Council (HPC).[1] It was made very clear at the start of my postgraduate diploma that without HPC registration, we were not licensed to practise within the NHS. Registration was considered important because this meant that I was practising under clearly defined quality standards and the public could be assured that I was safe to practise (BDA, 2008). It was the first time I realised what it meant to be a healthcare professional; being regulated and licensed to practise gave me a certain status with the general public and I felt proud.

That same year, I joined Stockton NHS Healthcare Trust – the first job I had applied for. I was overjoyed to be among the first newly qualified dietitians of my year group to get a job; I was now a healthcare professional, which would surely give me some status now that I had started working. How wrong I was to make this assumption. My first week on a general medical ward left me feeling that I had made the wrong career choice. As a newly qualified dietitian, in the NHS I found myself somewhere towards the

[1] The HPC is an independent body that registers and regulates 15 professions who meet the agreed standards for training (HPC, 2007).

bottom of a medical hierarchy that functions under a biomedical model of care.

The biomedical model is a reductionist approach that focuses on the physical process of disease (Engel, 2002: 50). The ideology considers 'professional knowledge' to be rational, scientific and evidence based. Although I understood this concept when training, the reality of depersonalising and objectifying another human being into the category of 'patient' was difficult for me to comprehend because of my family beliefs around Chinese medicine.

My thinking at the time was that consultant physicians, by virtue of their training and education, were considered to have more 'professional knowledge' and thus held the power and authority. This in turn was reinforced by general acceptance of this power and authority, not just from the public but also within the healthcare community. To some extent, I had been aware of hierarchy and status during my practical training; but assumed that this was because I was a student. I imagined that it would somehow change once I was a fully-fledged professional, with status and power of my own. Yet on joining the NHS, I felt as though I were invisible on the wards. During ward rounds, I was often missed off the list to have some input on patient care; or my advice was disregarded.

I expressed to my line manager how utterly frustrated, ineffective and professionally constrained I felt. Her response was that once I became

more senior, this would change; I took this to mean that seniority would give me more status and therefore more power to be in control of situations. However, having observed the relationships that my manager had with the medical community, I still felt that professionally we were not recognised as highly as the other professions. I was resolved that I would work my way up the ladder as soon as possible, so that I could gain status and recognition.

My assumption, based on my experiences so far, was that power was something that resided in an individual by virtue of their knowledge, authority and status within the organisation. In assuming the medics had more power, I in turn felt less powerful because I was not as knowledgeable about medicine. In comparison to other disciplines such as nursing and dietetics, the medical profession is a long-standing institution. In an article in the *British Medical Journal*, Ivan Waddington (1990) discusses the movement towards the professionalisation of medicine in the mid-nineteenth century and suggests that regulatory control was a way of creating a strong identity for medicine. The establishment of a controlling body that was underpinned by robust medical scientific theory, and which limited its membership to a chosen few, made the profession more exclusive, thus elevating its status. In comparison, Stacey (2010: 50) argues that when management aligned itself with the sciences of certainty as a way of legitimising the professional status of managers, this was more to do with

power, identity and ideology than with finding scientifically rational ways to govern an organisation.

At this stage, I would agree with both Waddington and Stacey: this long-standing institution, the medical profession, certainly seemed to explain why doctors seemed to wield such power. During those ward rounds, my inability to challenge the consultant physician stemmed from not wanting to be humiliated, or in some way undermined, in front of my peers if I said something wrong. I often remained silent, never speaking up if I disagreed with the consultant; this often led to me being forgotten or ignored, which made me feel invisible.

I am beginning to understand from my experience of being a participant on the DMan programme that there is an alternative way of thinking about relationships within organisations that is quite different from my previous experience. Members of the programme participate in a way of thinking called complex responsive processes, which challenges dominant theory around leadership and management.

> The theory focuses the attention on the importance of local communicative interaction in the living present, particularly its thematic patterning, its gesture–response structure and its reflection on ideologies and power relations.
>
> (Stacey, 2007: 412)

In understanding power within complex responsive processes, we the participants are encouraged to reflect on the views of theorists such as Norbert Elias (1978), a German sociologist whose theory focused on the relationship between power, behaviour, emotion and knowledge over time. Elias' view was that power wasn't something that a person carried around with them, could be given to others or taken away from them, or could be exercised over another. Power ratios are co-created within the relationship in the act of relating to one another (Stacey, 2007: 371). My experience began to shape my concept of how we are recognised and perceived by others within a power structure and how power ratios affect our actions.

Evidence is everything

I was fortunate that my first professional post was rotational: within 12 months I found myself in a very different environment, working as a community dietitian within a health promotion unit. Here, we focused not on clinical care for patients who were ill, but on working towards preventing illness through health promotion. Health promotion is the process of enabling people to increase control over their health and its determinants and thereby improve their health (WHO, 1986). It was considered the 'militant wing' of public health (Tones & Green, 2005: 3). Public health is a branch of medicine that deals with disease prevention on a population-wide basis (Winslow, 1920: 23) and has its roots in epidemiology and biostatics. My role on a day-to-day basis consisted of

working with health promotion officers to create health campaigns, develop literature and resources and give talks within the community to promote healthy diets and good nutrition. Within this unit, the hierarchy I had experienced on the wards – which I had come to perceive as various layers of leaders at the top making decisions and delegating instructions to subordinates – seemed to be absent: here, decisions were made more democratically. Although there was a manager, he did not exert authority unless consensus could not be reached. I felt able to express myself without fear of having my knowledge challenged in a way that meant I would self-silence. What I said seemed to be acknowledged and taken seriously; my confidence for voicing my opinion seemed to grow.

Health promotion was viewed as a relatively new science – considered quirky among the medical profession, because scientific evidence was difficult to measure and health behaviours viewed as difficult to change. This approach was totally different from that of conventional biomedicine: it embraced the psychological, social and cultural aspects of health. Indeed, promoting equity, tackling health inequalities and social injustice by empowering self and individuals, formed the basis of this discipline (WHO, 1986). To me, it felt altruistic; I was excited by this ideology – by a way of thinking and working that seemed more person-centred, focusing less on illness and more on well-being.

Keith Tones, Professor in Health Education at Leeds Metropolitan University (LMU), wrote much of the health promotion and health education literature used in my workplace during the early 1990s. He advocated the use of community development approaches and public health policy to establish population-wide change. I was particularly captivated by his definition of 'empowerment', which had a profound effect on the way I decided to practise:

> Empowerment is a state in which an individual actually possesses a relatively high degree of power: that is having a resource which enables the individual to make genuinely free choices. Power cannot be absolute and even if it could it would be undesirable since it would militate against the right of other people to make choices. Indeed one of the key features of empowerment is that system of checks and balances, which safeguard the rights of others.
>
> (Tones, 1994: 169)

This definition of empowerment reinforced my ideas of power as capacity and as something that was within me to give to others. It also reinforced the idea of systems approaches to convey that power. This was my first real awareness of using systemic approaches (which will be discussed further in my narrative) to change behaviour; but at this stage, I was mainly concerned

with how I would change practice and move away from a medical model of care.

Tones insisted that for public health policy to be effective within a scientific framework, it was crucial for health promotion to evidence the efficacy of interventions, which should all have a sound theoretical basis (Tones & Tilford, 1990). Most health promotion ideology was underpinned by empiricism – the acquisition of knowledge through a sense of experience and evidence. I accepted empiricism in the pursuit of evidence-based practice: this was the culture in which I had been brought up, and in which I was now practising. Although health promotion emphasised the relationship between the biological, psychological, sociological and, to some extent, the spiritual dimensions of people's experience – all of which, I felt, were critical to the understanding of health and its determinants, and challenged traditional discourse – I was still practising within the framework of biomedicine, encouraged to be an autonomous practitioner and objective decision maker.

Tones himself declared health promotion the 'militant wing' of public health because it did not fit with the traditional discourse around medical scientific theory. The movements of health promotion were primarily concerned with eliciting social change to improve health behaviours, which needed to be approached 'bottom-up' from a community development perspective. The first step was to know more about the

communities; to understand their needs and support them with health education. Only then would social action seek to influence local and national policy, to enable communities to exercise healthier choices. This contrasted greatly with the public health view that the primary function should be the development of sound public health policy, based on robust data, with decision-making embedded solely at the top.

My thoughts now on the ideology I was practising within are that in arguing for scientific evidence, Tones was in some way trying to gain recognition for health promotion by legitimising it through evidence-based practice and creating an identity that would be accepted within medicine. But I also felt that he was somehow subversively happy to perpetuate this 'bad boy' image of health promotion by regularly referring to it as 'militant'. In some ways, this still led to recognition by being, in some respects, a novelty compared to public health. On reflection, I began to consider the extent to which recognition – and our efforts to gain it – shapes the identity and status of professional practice and its relationship with power within an ever-changing organisational structure.

On completion of my postgraduate diploma, I was offered the opportunity to take up a Master's degree in Health Sciences, the focus of which subsequently became health promotion. Tones, then an academic at LMU, became my supervisor. Undertaking this research, I became more convinced of the importance of evidencing all health interventions to give

health promotion scientific credibility. It was during this research that I experienced my first organisational restructure. As a junior member of staff, I didn't comprehend it all, but managed to establish that the organisation was undertaking a review of all its managers, including heads of service, and radical changes in management were needed to make financial savings. Many policies and procedures were developed, informing staff of the process and the set procedures that would have to be followed in order to both manage staff anxiety and provide some order.

The proposals involved a loss of several heads of service, including in dietetics. We were given one meeting to consult – a meeting in which I somehow didn't feel that I was being consulted with. I was soon to learn that this seemed to be a process that NHS organisations would use when undertaking organisational change, in their desire to control and manage staff expectation and anxiety. However, the process only seemed to intensify anxiety, and certainly left my colleagues and me feeling that this was a 'done deal'.

Ultimately, we lost our head of service – a blow that shattered my illusion of the NHS being a 'job for life'. The health promotion unit had managed to identify some funding that enabled me to be promoted and the rotation stopped. I asked the health promotion manager whether my job would ever be affected by organisational change; he replied that as long as you justified your existence by evidencing practice to show how effective

you were, then it would be difficult for the organisation to get rid of the post. That statement was not enough to protect the health promotion manager. Within two years we undertook another review and, as health promotion units were now considered an expensive commodity, our unit was closed down. The manager was made redundant and I now moved into the community as a sole practitioner.

I was to spend another eight years within Stockton as a community dietitian. In 2001, I applied to become the dietetic manager: it was time, I felt, to move into a management role. As a clinician, I was frustrated by lack of control over policies and procedure, and wanted to have more influence within the organisation.

A new manager emerges

My Stockton application was not successful, but I was soon appointed to Durren Primary Care Trust[2] to manage a primary care and community dietetics team across three districts – a role that soon challenged my new motivation and idealism. Accustomed to managing just myself, I now had to manage 10 people who were accustomed to a relaxed management style and 'laissez faire' approach (Lewin et al, 1939):

> Laissez faire environments give freedom to the group for policy determination without any participation from the leader. The

[2] For the purposes of the reflexive narrative, names of organisations and individuals have been anonymised.

> leader remains uninvolved in work decisions unless asked, does not participate in the division of labor, and very infrequently gives praise.
>
> (Miner, 2005: 39–40)

As a clinician who had grown used to didactic processes and a culture of 'command and control' within biomedicine, it seemed that I had leaped into a chasm of uncertainty. Outside my comfort zone, I wondered anxiously how this team had managed to survive and function as a service: there were so many unwritten rules, customs and practices that seem to have no clinical basis. However, it had somehow survived in this form and I was viewed as the interloper, here to enforce unwelcome change. My role was to ensure that clinical governance procedures (explained below) would underpin quality of working to ensure safe and effective practice.

'Command and control', though commonly associated with the military, has become a familiar term in the current target-driven climate of the NHS. It locates power at the top where the government, through the Department of Health (DH), formulates its strategies and communicates down through regional command centres (Strategic Health Authorities; SHA) down to local organisations to be implemented. For me, this culture became more evident as a result of series of health scandals that rocketed into the public arena in the late 1990s. These included the Bristol Royal Infirmary scandal, where between 1984 and 1995 a high number of deaths

in the paediatric cardiac unit were recorded; and the Alder Hey Hospital scandal (1988–1995), which involved the unauthorised removal, retention and disposal of human tissue, including children's organs. Such scandals resulted in the NHS developing a new centralised system of 'clinical governance' through which NHS organisations were accountable for continuously improving the quality of their services and safeguarding high standards of care (RCN, 2003). I welcomed this initiative: always having worked in a culture of control, I believed this was the only way to optimise efficiency and minimise risk.

These incidents were the catalyst for the NHS to become more stringent and controlling of its clinical processes. This system of governance was translated into performance targets and performance management to ensure that the organisations were delivering effective patient care. As a new manager, I fell in line with the new thinking: patient safety was paramount, taking risks was bad, and it was good to control and contain where possible. I reflect now on whether we improved health care for patients and reduced risk through the 'command and control' approach to clinical governance procedures. More recently, a further scandal has emerged from Mid Staffordshire Hospital, where between 2005 and 2008, 1200 patients died – primarily through lack of A&E care (DH, 2009). An independent enquiry revealed that management were preoccupied with meeting targets, at the expensive of listening to staff and patients when

patient care started to suffer; and that staff felt disempowered to challenge systems failings because of the target-focused, blame-oriented organisational culture.

My initial thoughts about my new team were that this was just a 'storming, forming, norming, performing' phase (Tuckman, 1965). Having attended a foundation management and leadership development course, I knew about Tuckman's four-stage model for group decision-making; I felt I understood group dynamics and knew what I was doing.

In 2000, the government set out its intentions to reform and modernise the NHS in *The NHS Plan* (DH, 2000a). For the next five years, as part of the reforms, I saw my organisation aspiring to create a culture that would celebrate and encourage success and innovation (DH, 1998: 3). I was being encouraged to use systemic approaches to improve services, particularly in managing waiting times for patients. However, I didn't really understand what this meant and was more concerned with how the processes would support me to carry out the task (NHS Institute for Innovation and Improvement, 2005; NHS Modernisation Agency, 2004). Although I did not consider myself a systems thinker, I felt that everything I had come to know and learn in the NHS conditioned me to use systemic approaches to improve patient care. Of course, I was unaware of alternative ways of viewing things.

Part of changing the culture within the NHS was to also enable the development of leaders and clinicians with the right capabilities to innovate and improve services. As a result, my organisation would take on the characteristics of a 'learning organisation' (Davies & Nutley, 2000). I had always understood that learning was something undertaken and developed by the individual. Learning organisations were viewed as having a central role for enhancing the personal capabilities and then mobilising these within the organisation to improve the organisational capabilities (ibid: 998–1001). So the development of leadership courses, such as the one I attended, focused on developing my skills around leadership, managing change, strategy, visioning, decision-making and team building. Heavily focused on leadership styles, the course content drew on work by popular 'learning organisation' theorists who advocated systems thinking – such as Senge (1990), whose organisational learning theory formed the framework for the course; Argyris and Schön (1996), whose work described different levels of learning; and Mintzberg's work on cultural values (Mintzberg et al, 1998). They also drew on popular leadership style theorists such as Lewin (Lewin et al, 1939), Likert (1967), Adair (1973), Hersey and Blanchard (1999), Bass (1985), Burns (1978) and Covey (1992). My thinking began to move away from organisational structures of command and control, towards one where I was encouraged to consider objectively the nature of – and relationships between – the outside world, the organisation, my colleagues,

and myself, in relation to service improvement. After a week-long course, I felt equipped and motivated to lead; the leadership training had somehow given me the impression that day-to-day life would follow a predictable pattern. I looked forward to becoming a competent leader who could deal with situations as they arose.

Within the first month, three dietitians had handed in their resignation. Each covered a large number of clinics; to cancel these would increase waiting times for patients, in breach of performance targets. Clearly, management was not what I had anticipated; I struggled to control the process. The situation was worsened by the fact that I was unsupported: my new manager was also struggling in her efforts to cope with an organisational restructure at a more strategic level, with management structures again under review. Though I could not make sense of what was happening, I realised I was not in control, which heightened my levels of anxiety.

In his book, *Paradox of Control in Organisation*s (2001), Streatfield explores his own experiences of control and in terms of paradox, which he describes as 'the simultaneous coexistence of two contradictory movements' (cited by Stacey, 2007: 7). Streatfield proposes a way of thinking about organisational dynamics that are paradoxical, in that as a manager he experiences being 'in control' and 'not in control' at the same time. Similarly, here I felt in control of the processes that I wanted to implement

to improve performance, yet not in control of the outcome. The team seemed to covertly resist change by accepting tasks but not carrying them out – resulting in a tense standoff where members of staff were not prepared to accept my authority, preferring to leave. All the leadership theory I had learned within the NHS suggested that improving my personal capabilities would equip me to lead in challenging times. However, while the training had been on developing individual skills and competencies, this was of little use in managing a process over which I had little control and where I could not foresee the outcome.

Ignoring what I thought was correct practice, I began arranging individual meetings with every member of staff. I wanted to learn about them and create some relationship as a basis for mutual understanding, while also explaining the seriousness of the predicament we were in. Where possible, I arranged agency cover to maintain clinics, cancelling some where necessary, so as to minimise pressure on the other dietitians. All the governance issues were put on hold. The team appreciated this, as in the past each dietitian had been expected to cover for their colleagues; cancelling clinics had never been an option. The resignation of three team members had therefore created considerable anxiety. Providing this extra cover was expensive, but was better than overloading staff. This was a turning-point in my relationship with the team, which improved considerably as we began to communicate better with each other.

Professional leadership in question

In 2004, I had just been appointed as overall service manager and professional lead following the retirement of my line manager. The DH wanted to radically review the pay system, and introduced their 'Agenda for Change' (AFC) (DH, 2003) to ensure that all jobs were evaluated and graded equitably, linked to a consistent pay scale. Everyone's job description would be peer reviewed, according to set criteria – a fairer way to assess pay, and also less costly if every organisation was responsible for its own evaluation processes.

All staff were asked to join collectively similar professional or job groups, to self-regulate and to rewrite their own job description. No one could agree on an effective job description, so everyone over-inflated their own role – a process that pitched profession against profession, amplifying rivalry, despite the DH's stringent criteria. All practitioners had their own professional bodies to support their members through this process; it seemed inevitable that some of these were more vocal and powerful than others. Locally, the professions were given a free hand to develop their own job descriptions. Many allied health professionals (AHPs) became precious about their own jobs and appeared to feel that their profession merited a higher grading. In contrast, dietitians nationally as a staff group were not evaluated very well compared to their peers. Locally, this ignited bad feeling between staff and management.

I blamed my professional organisation (the British Dietetic Association; BDA) for the ensuing power struggles: they had been slow to advise staff how to write a useful and meaningful job description. It also seemed easier to blame the BDA than examine how we might each help to shape the outcome; I was still thinking in terms of power being held by groups and individuals. I understand now that these shifts in power would have happened as a result of groups interacting with one another, even if one group is viewed as having more power than the other.

I had a foot in both management and staff camps. I had inherited another new manager who had only known me for a few short months; the operational directorate was facing its second interim director, who was trying to bring financial balance to the organisation. To my dismay, I was pressured to ensure that staff grades were kept low, to minimise financial impact. Almost three-quarters of my 40 staff had been graded low, in my professional view; they had lodged complaints about the process and were appealing against the decision. My manager blamed me for the number of appeals being lodged and my lack of 'professional judgment' when developing job descriptions. She too was being performance managed on AFC; though the NHS reformation encouraged staff to learn from mistakes within a blame-free culture that would allow them to challenge the organisational hierarchy, in reality this did not happen. This was acknowledged in yet another DH report, *An Organisation with a Memory*

(DH, 2000b), which noted a tendency for NHS organisations to blame or scapegoat one or two individuals when things go wrong.

I faced the dilemma of trying to implement a national pay scheme intended to promote equity in grading job roles, while somehow avoiding pay increases that would impact financially on the organisation. In trying to make sense of what was happening through my understanding of complex responsive processes, I turned again to Stacey, who refers to Wilfred Bion (1961), a psychoanalyst who pioneered group dynamics. He makes the distinction between different types of leader; each occupies a precarious position – placed there and controlled by the group, rather than vice versa (Stacey, 2007: 120). I felt forced into an impossible position: as leader, I was expected from a professional standpoint to be immersed in the interaction with my staff, yet from a managerial standpoint to be emotionally detached and remain objective. In reality, I felt more aligned to my staff – perhaps because I still identified myself primarily as a dietitian. George Mead, an American philosopher, sociologist and psychologist, offers the perspective that organisations have a ‘tendency to act’ – a ‘generalisation’ (ibid: 307) that would be made particular to that time and situation. Stacey refers to organisational strategy as generalisations, suggesting that conflict may arise from how we interpret and take up the generalisations at a particular moment (ibid: 309).

With everything I understood about leadership, I felt unable to fulfil my professional and managerial roles simultaneously. I had to make a decision on either one or the other, because everything I had learned and experienced so far was that leadership was about me as an individual and my ability to make autonomous decisions. I think I was in conflict with my manager on how each of us were interpreting the situation or particularising the general. In the conflict that arose, I felt that the changing power dynamics forced me to choose a position; I chose to stand by my staff and attempt to defend the profession.

The rise of the trouble-shooter

In 2007, I came under the management of a new interim Director of Operations (DOO). The structure of senior management was still unsettled, although there was now a core group of us who seemed to be getting on with the job and supporting one another with day-to-day issues through informal chats in the corridors or in the staff kitchen or canteen.

Our operational service team was fluid, with people coming and going. There didn't seem to be enough people to take on additional work; but the interim DOO persuaded me to take on the audiology service, as I was perceived to have had capacity. As soon as I accepted this new responsibility, I was warned that the service was very small, community-based and consultant-led. There were issues with the team, who – though

generally a nice group of people – were viewed within the organisation as underperforming. I would be their third manager in two years.

> Performance management as a natural process of management is a process, which contributes to the effective management of individuals and teams in order to achieve high levels of organisational performance. As such, it establishes shared understanding about what is to be achieved and an approach to developing people, which will ensure that it is achieved.
>
> (Armstrong & Baron, 2005: 2)

Allegations had been noted, high up in the organisation, of a previous member of staff bullying other staff members; while having no evidence for this, the DOO felt that the management and leadership was weak, leaving the team demotivated and functioning poorly as a team. She also mentioned that we were about to be nationally monitored on a new waiting time target. I rapidly considered the implications for myself of this ‘underperforming’ team having to meet national performance targets within the next 12 months. The DOO finished the conversation with the fact that the CEO was taking a personal interest in meeting this target, particularly as the monthly league table would be made available across London so that each organisation could review their performance. Failure was clearly not an option.

I needed to meet with the consultant audiologist, Dr Harper, to get some background information on the service, which I expected to have a hierarchy similar to what I had experienced as a junior dietitian on the wards. Despite assurances that Dr Harper was a lovely man, I was anxious about meeting him: memories of feeling invisible and powerless on the wards resurfaced. It's interesting how experiences of the past can have such an effect on us and how we reify a group (in this case, doctors), ascribing certain characteristics to them and generalising these. Based on my own experience of doctors, I anxiously anticipated having less power and status.

I couldn't have been more wrong about Dr Harper, who was approachable and friendly. I was struck by the mutual affection and respect all the staff members had for him. The day-to-day operational work was efficient, and the team were meeting waiting time targets originally imposed on the service; I could not understand how they were viewed as underperforming. Senior management apparently failed to recognise that team dynamics were actually very good; as a result of this lack of recognition, there seemed to be an assumption of performance issues. Perhaps gossip was having a detrimental effect on the identity of audiology, resulting in them being labelled as an underperforming team. I was concerned at the implications for them of such stigmatisation, which I had experienced in the past where smaller, weaker teams low down in the organisation had been deleted from the structure or subsumed into bigger

services. I wondered about an ulterior motive at executive level, such as plans to restructure the service.

Stacey (2007: 355) points out that gossip can reinforce power differences; I felt that the DOO was responding to hearsay based on one negative incident, which in turn led her to make a generalised statement about the group that in her eyes had become a truth. If audiology were to fail against performance measures, would this give the executive team an excuse to radically review the service – perhaps even decommission it? I now begin to question the power of gossip as part of communicative interaction among executive leads that can give rise to a particular judgment and methods by which they exert that power.

Another viewpoint could be taken from Nancy Fraser (2000), an American critical theorist and feminist thinker, concerned with conceptions of justice in the redistribution of power, equality and wealth. She argues that recognition is based not on identity (what audiology represents to the individual), but on status acquired through social interaction (actual social relations and participation in forms of activity). What resonates for me in this example is that judgment could have been made on individual contributions towards the service, rather than basing it on a collective representation formulated through gossip.

In summary

I'm aware of central themes that run through my narrative, linking the processes of recognition to power relationships, status and identity. At the beginning of my career, I struggle to form an identity around my profession as a junior member of staff within what I perceived as a powerful medical hierarchy that existed in an organisational structure. Unacknowledged within this hierarchy, I experience minimal status and power, which limits my ability to practise effectively. I then move into a situation within health promotion where I no longer perceive hierarchy within my immediate structure, but within my evolving practice I begin to understand that health promotion itself is not recognised in a traditional biomedical model of healthcare. To legitimise this practice, I therefore rigorously apply scientific method to my way of working, which reinforces the way I think about my identity as an autonomous practitioner. Moving into middle management, I reflect upon the need for my organisation to exert control in its desire to promote stability; I become aware that leadership skills and competencies are inadequate preparation for conflicting and contradictory situations, which I begin to realise are inevitable in the act of relating to others. What is also inevitable in the act of relating is conflict, which relates to power dynamics and power relationships through communicative interaction.

When my leadership is in question, I find myself at odds with my manager, and perceive different power dynamics occurring in my

relationship with my team versus the ongoing conflict with my manager. I'm unaware of how this may influence how I am recognised by others. Finally, I take on a service that I feel is not recognised by the organisation for the good work it has done, but rather reluctantly acknowledged because its performance will be monitored London-wide. I am aware of the potential for groups or individuals to be misrecognised. Any restructure that I have experienced seeks to 'rationalise' (reduce) middle management, often leaving the remaining operational managers struggling to cope with a larger portfolio of services. I find myself becoming more distant from frontline staff, increasingly reliant on my team managers to convey information. This raises concern when you start to implement organisational changes that involve restructure of services because it becomes much more difficult to stay in touch with frontline staff when you have more areas to manage and fewer team managers to support you.

What I was experiencing as a new manager, and in the situation where my professional leadership was questioned, was conflict. Griffin (2002) argues that conflict is a necessary and unavoidable part of everyday life. Drawing on the works of Elias and Mead, Griffin points out that the mainstream literature of leadership appeals directly to cult ideals: 'their systems thinking has the effect of covering over ideologies and splitting off tendencies to challenge power' (ibid: 197). My understanding from what I have read is that in the struggle to recognise diversity, conflict arises.

Griffin argues that without conflict, there would be limited possibility for transforming identity. For Mead (1934: 217), the essence of leadership is the recognition of actively dealing with difference: the leader acts 'with reference to a form of society or social order which is implied but not yet adequately expressed'. I interpret social order to mean a hierarchy or structure within the NHS that is implicitly understood but not explicitly expressed.

What I understand now is that as a middle manager, my relationships with frontline staff, peers and executive managers are shaped by the process of interacting and the changes in power dynamics arising from conflict. This becomes apparent when having to translate government policy into day-to-day operations. The outcome of interacting somehow relies on a process of recognition of an individual by the other, and the degree of recognition seems to relate to identity and status.

I'm interested in how we make sense of national policy and how this is taken up within my organisation, as well as what this means for myself as a middle manager who is required to interpret and implement these policies. I'm also interested in how frontline staff respond to the operationalising of national policy. My research question is therefore: How do we translate government policy into day-to-day operations within an NHS organisation? Participating in the DMan programme has opened up a way of thinking that seems to offer a more plausible way of making sense of those situations I

have had difficulty in understanding through traditional management and leadership theory. I hope to be able to explore these themes in more detail in my subsequent projects.

Project 2

Processes of responding to the strategic directives in an NHS organisation

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Introduction

In early 2010 I was employed by NHS Durren as a general manager, managing three clinical services – Nutrition & Dietetics (for which I was also the professional lead), Audiology, and Musculoskeletal Physiotherapy – for the provider arm of the organisation (responsible for delivery of clinical care to patients in the community). The Operations Directorate was led by a Chief Operating Officer (COO) who reported to the CEO. He in turn managed an Assistant Head of Operations, to whom I reported. There were nine general managers in NHS Durren, each of whom managed a number of services that made up the provider arm.

My responsibilities included the management of day-to-day operations of the services within my portfolio. This included implementing the strategic directives that the executive management teams had outlined and ensuring that the services were performance managed to meet internal and DH targets. As a middle manager, I found myself straddling the boundaries between the executive management team, who formulated strategic directives, and the frontline staff who had to implement them. I

was expected to follow implementation plans without question; yet interpreting and actioning the directives was not always straightforward, particularly when there was a requirement for organisational change. Tensions, often emotive, arose when strategic directives conflicted with the delivery of patient care.

Drawing on my own experience in the NHS, I intend to explore in this paper how managers of specific healthcare delivery services respond to strategic directives requiring organisational changes. This gives rise to my research question: What are the processes middle managers engage in to interpret what the initiatives and changes mean in their specific situations, as a basis for carrying out the instructions presented by executive managers who are in turn responding to government policies? The narrative that I present centres on government policy requiring the NHS to make 'efficiency savings' with the aim of reinvestment in patient care. At a local level, this manifests as a strategic directive for cost cutting, which leads to streamlining a management structure moving from one organisational form of an alliance into another, merged, form of an integrated care organisation (ICO).

This paper illustrates examples of events leading up to the integration and the conversations that took place within the ICO. The focus will be on how the relationships between myself, my managers and other key organisational staff affected the way we responded to the directives. I

propose that implementation of strategic directives is not straightforward, however carefully planned, because the process of responding to directives depends on the relational aspects that managers have in their day-to-day interactions with others – so applying systematic approaches to planning and communicating may be inadequate to support organisational change. Particular focus will be give to understanding day-to-day interactions as a process of response, through the theory of complex responsive processes; in comparison to theories of systems, which to some extent reflects the ideology of the NHS.

The strategic directive of forming an alliance

In April 2009, the Labour government was finalising its implementation of its 10-year plan to reform the NHS. As part of the reforms, Primary Care Trusts (PCTs) would cease to exist by 2011; in the interim process, their commissioning side (responsible for buying health care for its local population) would split from the provider arm. This would result in two separate parts – both still responsible to the CEO, but functioning very differently from one another.

The executive team decided that NHS Durren and NHS Wyth should integrate with the hope of becoming a community foundation trust. Although we would not officially become an alliance until the latter part of the year, staff from both organisations were encouraged to think about themselves as an alliance, and middle management teams to form

partnerships. For the first six months, the directorate leads and senior managers met regularly to try and bring the two organisations together. The first couple of meetings were fraught with tension as each organisation sought to establish itself with the other: this was clearly not going to be as easy as anticipated by the directorate leads. Our Wyth colleagues seemed unhappy about being forced into an alliance with an organisation that was just coming through the aftermath of a second high-profile child protection scandal and was viewed as the 'poorer relation'. When asked to describe themselves, the two teams of middle managers expressed very different views of their own organisation.

As part of the middle management structure in Durren, we saw ourselves as traditional and well established, with loyal staff who tended to stay a long time. Although we were on our seventh interim director, we felt this strengthened our team, making the operational function secure, strong and dependable. In contrast, Wyth viewed themselves as young, vibrant, innovative, charismatic and successful. What became apparent from initial meetings was that Durren were open to joining with Wyth, albeit reticent about being seen as the Cinderella organisation; whereas Wyth were clearly wondering why they should be joining an organisation that was rife with scandal, lacking charisma and perceived as substandard.

Naturally we became defensive, thinking the Wyth managers were caught up in their own self-importance. The managers they sent to meetings

with us were graded higher than ours, despite the fact that the roles were similar and Durren managers had larger portfolios to manage. While the Wyth managers were friendly and cooperative, we could not help feeling that their general attitude towards Durren must be reflected throughout the Wyth organisation. If so, how could we possibly find common ground if our Wyth colleagues did not really want to be our allies? The answer for the executive team was to develop an action plan, with risk assessments and timelines, to ensure successful integration.

The change in strategy directive of moving from alliance to ICO breeds discontent

Durren and Wyth executive leads spent the next 12 months carrying out the action plan in an attempt to iron out the differences. They still encouraged managers to engage with their counterparts across the boroughs. At this time, I was managing Nutrition & Dietetics and Audiology. I was asked to engage with the dietetic manager in Wyth – not difficult, I felt, given that the Wyth manager was a friend. Priya and I had known one another for a couple of years, and had already begun to share protocols and procedures following on from the early alliance meetings.

However, early in 2010, it became clear that at a national level, the NHS was experiencing financial difficulties. Government policy highlighted lack of tolerance for inefficiencies within the NHS and reduced productivity. The intention of government policy was to cut NHS

management costs over the next five years, indicating that this would extend right across the board – including senior managers and even clinicians. Any financial savings would be determined at a local level, seemingly devolving responsibility from central government; but they would not dictate how local NHS organisations should achieve these efficiency savings.

Our executive team decided to make savings across all services through cuts in the management structure. This formed the strategic plan; it was assumed that the rationale would be understood by the middle managers who would be expected to implement the decisions. For the Durren managers, this came as no surprise. We had grown accustomed to a climate of financial pressure over the last few years, and used to making efficiency savings annually. In contrast, our Wyth colleagues had little experience of this and were clearly unhappy about the prospect, particularly as this meant their middle managers would now have to take on much larger portfolios in an attempt to move them away from uni-professional management and position the Wyth structures to align more readily with Durren.

Systems theories that have influenced executive decision-making in the NHS

In Project 1, I discussed that throughout my NHS career I had been trained in systems thinking and that even though I did not necessarily believe that this was always the best way to deliver patient care, I was groomed into this

way of resolving problems, reducing risk and improving service delivery. There are two theories I feel have influenced executive decision-making within the NHS. Firstly, strategic choice theory, which very much reflects the 'command and control' approach that I experienced in my early NHS career. This theory, first proposed by John Child in 1972, argues that organisational form can be directed and influenced by powerful groups who act autonomously and from a position of objectivity, and that this course of action enables predictability within a changing organisation. Child's perspective on strategic choice is that the way organisations are designed and structured is determined by the operational contingencies (Child, 1972: 2). The theory draws attention to the active role of leading groups who have power to influence the structures of the organisation and decide the course of strategic action. Decision-making is fully embedded at the top of any organisational hierarchy. It also assumes a prescriptive nature, that change can happen through a simple process: an executive decision is taken by the very senior management team, and carried out simply by motivating others.

In the NHS, only the executive teams made strategic decisions. They were goal orientated, and focused on actions to achieve that goal and measure performance towards it. Control was understood as strategic directives – outlined in aims and objectives and expected outcomes, all of which would have action plans attached. Each objective would be risk assessed and plans would be developed to mitigate risk. The whole process

would be continually monitored and performance managed until the objective was met. This type of approach is regulatory; parallels can be drawn with a cybernetic system (a term first described by Norbert Wiener), which is a self-regulating, goal-directed system that adapts to its environment. The point of this process would be to rule out any degree of uncertainty of a situation by continually risk assessing (Wiener, 1948).

My organisation had begun a shift towards encompassing elements of learning organisation theory. From this perspective, decisions around change still happen at the top. This systems approach differs from the cybernetic approach in that it proposes that organisations are successful when their personnel learn together. There is still the element of control, but it is acknowledged that unexpected responses can occur during change. Senge, among the most influential authors with regard to this theory, proposes that responses can be achieved if executive decision and influence are exerted at 'leverage points' – defined as those points where managers can exert influence and have an impact on the behaviour of that system (Senge, 1990: 40). Senge believes that leverage points can be identified if managers practise the discipline of mastering self, changing their mental models and those of others by building a shared vision, encouraging the team to learn and engage in systems thinking.

One reason for the popularity of organisation learning theory within the NHS is that it has been seen as a way of responding to uncertainty,

maintaining flexibility and competence in the face of rapid change (Davies & Nutley, 2000). Rather than implementing fixed responses to change through command and control, such as in strategic choice theory, learning organisational theory seeks to develop structure and human resources that are flexible, adaptable and responsive but also possess a willingness to learn in order to improve capacity and hence compete (ibid: 2000). My interpretation of Senge's key features of learning organisational theory is that the following aspects are crucial:

Open systems thinking – enabling people to interconnect across a wider community of activity, which may be interdisciplinary or multidisciplinary and internal or external to the organisation.

Individual learning and personal proficiencies. To a certain extent, I agree that self-improvement is necessary; but what I experience in health care is the tendency for people to gain knowledge within their own disciplines, which tends to lead to 'siloed' working.

Team learning. Senge insists that achievement in organisational learning is dependent on teams, and that teams should be created to exert wider influence. Again, I agree on this point – fostering teams and shared purpose is certainly paramount to delivering effective services; but for me, the notion of joint learning is not enough to enable a common sense of purpose and mutuality. Also, in the development of teams diversity will

inevitably become apparent as each team begins to develop its own sense of identity.

Updating mental models. These deeply held assumptions and generalisations influence how we each make sense of the world. Senge does not explain the process by which their ‘updating’ should take place; but these models link to how cause and effect are tied conceptually, and constrain what individuals see as possible for the organisation.

A cohesive vision. Encouraging shared understanding of this vision and commitment to it is crucial in building a learning organisation.

Management approaches that have been influenced by a cybernetic systems dynamic presume that managers can design, control or exert influence to achieve the objective or carry out the strategic directive. They also assume primacy of the individual over the social – a point I will come back to question later. It is understood that the right implementation plan will ensure the desired outcome. My objective was to achieve efficiency savings, so any change within the organisation was directed towards achieving this goal. In the systems dynamic approach, it is believed that managers can exert influence to attain the desired outcome in order to achieve a given objective. So what did this actually mean for the middle managers, in terms of expectations of the executive team around implementing strategic directives? How did we cope with the sudden change in direction from alliance to integration?

What are middle managers expected to do?

The theories that have influenced the NHS provide a backdrop to how decisions were made within the organisations and the controlling nature of the executive team. There was an expectation that middle managers would carry out the implementation, which was rationalised as being in the best interests of patient care. When I refer to 'strategic directives' in the NHS, I mean actions that are normally taken to translate and implement policy. Graeme Currie's paper on the influence of middle managers in the business planning process argues that middle managers influence by modifying the implementation of deliberate strategy. He describes middle managers as purveyors as well as recipients of change, and acknowledges that translation of ambitious change into practice has always been a problem (Currie, 1999: 6). This, I feel, is reflected in my example of a sudden change in direction: moving from alliance to integrated care organisation. Empirical studies show that policy intentions are never fully realised (Harrison et al, 1992, 1994). There is acknowledgement that implementation failure persists within the NHS because approaches to strategic change still separate the design of strategic change from its implementation. More importantly, it does not allow for any consideration of middle managers beyond implementation (Currie, 1999). The suggestion here is that middle managers would be able to influence the process top-down and bottom-up. Currie further concludes that the success of strategy is attributable to middle

managers – that is, located within the key individual. By contrast, strategy can also be viewed as a process approach (Mintzberg & Waters, 1985; Pettigrew et al, 1992) and defined as ‘a pattern in a stream of decisions’ (Mintzberg & Waters, 1985: 257–272). From this perspective, strategy is emergent as well as being deliberate, rational and top-down (Currie, 1999). For Pettigrew (1985), strategy as a process not only reflects top-down management but also represents a set of practical concessions between various key people.

All these authors are suggesting that strategy results from decisions, and it is assumed that there is a prescriptive nature to this process: as long as you carry out *A* and *B*, then *C* will logically follow. These representations of decisions, which we understand as ‘strategy’, will be understood and accepted because they have been formulated by people those in power who know what is best for the organisation, and are translated into coherent plans and frameworks that can be actioned. Furthermore, the success of strategy is dependent on key individuals (in this case, middle managers), with the implication that they can exert influence and drive change.

What I propose is that implementing directives that lead to change is not so straightforward. In my narrative below, I conclude that even when we had systematic plans in place and the right individuals to implement these plans, we could not always ensure that the desired outcome was met, because people did not always react to change as we expected. There was

resistance among both sets of managers as the executive team insisted on our integration. The strategic directives also changed: not only we were being told to share good practice, but there was now also a real possibility of our management structures being streamlined. This meant managers taking on responsibility across two boroughs, and potential job losses; and this provoked anxiety.

I now wish to consider a way of thinking about strategy that contrasts with mainstream management theory and which may start to give some different insights into how we think about the processes of responding to strategic directives. Strategy can be described as intentions to act, as described by the authors referenced above. Strategy is presented as arising in a rational and objective way from the desires and intentions of individuals and groups such as the executive team.

Another theory of understanding how strategy develops is the theory of complex responsive processes, which I introduced in Project 1. From this perspective, strategy can be thought of as population-wide patterns of activity. Stacey describes strategy as generalised articulations of ongoing patterns of activity (Stacey, 2010: 351). Strategy is not realised through individual desires and intentions, but through interplay of intentions, which Stacey defines as the 'embodied interaction of human person acting with intention and also quite unconsciously without intention' (ibid: 351). I could therefore describe the pattern of activity I am engaged in as 'integration' of

the organisation, as well as another pattern of activity called ‘efficiency savings’. Interplay of intentions arises in local interactions between people, which in turn takes place as communicative interaction.

In exploring the theory of complex responsive processes in Project 1, I referred to George Herbert Mead – an American philosopher and pragmatist, who examined complex social acts and how conversation is linked to this by establishing meaning through interaction of humans relating to one another. His term ‘generalised other’ refers to complex social acts in which people have the ability to take on the attitudes of other. To accomplish this through relating, people are able to generalise the attitudes of many at the same time (Mead, 1934). Mead viewed attitudes as *tendencies to act*, which he referred to as generalisations (Stacey, 2011: 354–355). These generalisations would be made particular to that time and situation. Stacey’s further interpretation of Mead is to refer to organisational policy or strategy as generalisations; he notes that conflict may often arise in how we interpret these generalisations – how we make them particular to situations at any point in time (Stacey, 2007: 307–309).

What Mead is saying seems appropriate to understanding the difficult situations that I find myself in as a middle manager. I feel that I am often immersed in these generalising and particularising processes when I attempt to understand government policy and particularise this into practice. This becomes evident through my interactions with others. Conflicts and

tensions arise in conversation as I explore the meaning of the strategy. Mead's thinking adds an important element to this inquiry, in that it enables us to begin to understand how to make sense of strategic directives, seen as ongoing patterns of activity, in the way that we interpret and make particular the directives to our own situation. This can be very different from one individual to another.

Particularising situations of paradox gives rise to dilemma and double bind

In understanding how we make these generalisations particular, the following telephone conversation is an example of how I was interpreting and making particular the strategic directives. At the beginning of April, Priya rang to ask if I had heard any updates on the organisational change. I denied that I had, even though I already knew what was happening to Priya: as she explained, her manager was restructuring the senior management teams and she would be demoted. She would now be managed by Charlie, the physiotherapy manager. She was upset about this, and annoyed that her manager had announced this at a senior managers' meeting – to her and Charlie's embarrassment – without giving them any further opportunity to discuss the implications. I felt some guilt at concealing the fact that the previous week, my managers had mentioned radical changes to the management structure in Wyth. Of course, I had debated whether to tell Priya; but decided not to worry her, in case the executive decision changed.

I asked what she was going to do, feeling uncomfortable that I had been withholding this information for a week. I knew Priya would be upset that I had kept this from her and I did not want to jeopardise our friendship. Priya spoke of not being happy being managed by Charlie because she viewed Charlie as her equal and felt that Charlie would not understand the professional issues. At this point, I was sympathising with Priya both as a friend and as a fellow dietitian. I could understand that it must have felt terrible to be demoted – not only from a personal perspective, but also the need to protect professional leadership in our specialty. Priya then began justifying why Charlie could not manage dietetics – explaining that dietetics was a complex service with a lot of external contracts that only she had the expertise and knowledge to deal with. At this point, my thinking switched: I wondered whether Priya was aware of any of the policy changes and strategic directives that were happening. As a manager, I felt exasperated that she did not appreciate how the financial situation we were facing meant that it was now considered a luxury to manage just one service. At the same time, as a friend, I was sad for her, knowing that she was a victim of circumstance: had she been a higher or equal grade to Charlie, things may have been different.

Priya was deeply upset at the lack of discussion and consultation regarding the changes to her position. She reported that she was unhappy about being managed by Charlie, as the relationship would now change

from equal to subordinate. She felt that it was a backward step for the profession to cease having a dietetic lead represented at their senior management meetings. Priya had no personal antipathy towards Charlie, but felt that a physiotherapist was not qualified to make decisions about our profession. Indeed, Charlie herself was feeling awkward about the whole scenario and the way it was presented to her. Priya was keen to have my opinion. She viewed me as a fellow professional, rather than a senior manager. Given my prior knowledge of her dilemma, I searched for a sincere response. On the one hand, I understood Priya's personal and professional frustrations; on the other hand, I understood the organisational need to restructure within the context of our response to efficiency savings. I understood the need to broaden the senior management portfolio: individuals managing a single service was not viewed as cost effective. I kept finding myself defending the argument for efficiency savings.

Reflecting back, there were points in the conversation where unconsciously I felt I took three roles simultaneously: a friendly shoulder to cry on, a professional colleague who shared Priya's concerns about generic management, and a defender of the organisational strategy. At times, I felt sympathetic to Priya's reasoning; at other points, I was frustrated with her logic and she became defensive. I did not feel she was seeing the bigger picture in terms of efficiency savings and the fact that if we did not make some radical changes to the management structures there would not be

enough money for patient care. I suspect that her overwhelming thoughts about her own position were in some way preventing her from understanding that these radical changes needed to be made. I tried to placate Priya by focusing on sympathy for her personal plight of being demoted. Not wishing to increase Priya's distress by explaining that I agreed in principle with some of the radical management changes, I suggested that she ask for her job description to be reviewed – although I knew an upgrade was unlikely because Wyth had to save money. She agreed that this would be a good plan; in the meantime, she would try to work alongside Charlie.

Making sense of paradox, dilemma and double bind

To understand what was happening in this interaction with Priya, I will be referring to a number of authors who have varying thoughts around paradox, dilemma and double bind. I played the part of friend, manager and professional colleague all at the same time. I was conscious of my thinking as not being static or consistent, but contradictory. Responding to Priya, I could not know what she would say next or which role I would assume; this created tension and anxiety for me, which in turn led to incongruence between what I verbally expressed and my internal thoughts.

Stacey offers a detailed explanation of how we might regard contradiction in defining a way of thinking about paradox from a complex responsive process perspective (2011: 35–36). He explains that

contradiction can be thought of in a number of ways: as *dichotomy*, where there is a polarised view requiring choice, as a *dilemma*, where the choice is between two equally unattractive alternatives; in *both/and* terms, a dualistic way of thinking where both choices are considered by locating them in different spaces and time; and finally, as *paradox*. A systemic perspective tends to consider paradox as two conflicting elements that operate at the same time, with organisations seeking to resolve this either by choosing one element over the other or by 'reframing' to provide another perspective that eliminates the contradiction. Paradox can also mean two diametrically opposing forces present at the same time, neither of which can be resolved or eliminated.

A dilemma can be defined as a situation where a difficult choice has to be made between two alternatives, especially when a decision either way can bring about undesirable consequences (Ehnert, 2009: 132). It can also be defined as an either/or situation, where one alternative must be selected over another (Cameron, 1986: 542). Dilemmas are therefore characterised by a situation where a choice has to be made between two equally undesirable alternatives (Ehnert, 2009).

'Double bind' was first described in 1956 by Gregory Bateson, an anthropologist and social scientist who was examining the aetiology and nature of schizophrenia. He described a situation in which no matter what a person did, they could not win. This identification of specific constraining

interactions he articulated as a form of dilemma that he called ‘double bind’ (Bateson et al, 1956; Bateson, 1972). For a double bind to occur, a number of ingredients are necessary: an interaction between two or more people; a repeated experience; contradictory injunctions; an inescapable field of communication; and a sense of failing to fulfil the contradictory injunctions (Bateson,1972: 251).

It is possible to draw on these perspectives to interpret what was happening between Priya and myself. She exposed her feelings to me and I was unsure what kind of response she expected, or how I would actually respond. The situation was paradoxical in that there were simultaneous tensions resulting from efficiency savings and improving patient care. The dilemma for me was that if I agreed with the decision to restructure, this might jeopardise our friendship; but if I agreed with Priya that she had been treated unfairly, then I would be betraying my middle manager’s commitment to the need for restructuring in order to make savings for patient care. I was also deeply uncomfortable about having withheld the information that her position would change. I felt that Priya would be upset if she found out, and equally upset if I did not agree with her. Ina Ehnert explores paradoxical tension in her book on sustainable human resource management, asserting that paradox can become a dilemma in any instant that action has to be taken (2009: 136). If I consider the shift in ways of thinking as resulting from the coexistence of contradictory forces, then

according to Ehnert's assertion, the moment I felt I had to make a decision was the moment that dilemma was created. The tension that unfolded resulted from feeling that I had to make a choice on how to act knowing that neither choice was acceptable. This then meets Bateson's criteria for a double bind: two conflicting messages negated each other, meaning that I could not confront the inherent dilemma. In the end, I took the decision to agree to the unfairness of the situation; but in avoiding conflict with Priya, I created mental conflict within myself.

I would therefore suggest that the way in which we particularise as individuals is not straightforward, and is dependent on the relational aspect of interaction with others when we are communicating. Making particular generalisations where paradox exists, depending on the relationship with the other, can lead to dilemma. If decisions need to be taken that are not acceptable, an inability to resolve this dilemma or confront it can give rise to a double bind. In this example, I made a choice, and what arose from the interaction was not conflict with Priya but my own internal turmoil at feeling that I had been insincere. The process of responding in our daily encounters is dependent on the relational aspect of interaction with others when we are communicating. A systems approach to communication that is modelled on a sender–receiver model is not helpful in explaining difficult situations such as this conversation with Priya.

Mead, communication and the processes of responding

At this point, it would be helpful to draw on the ideas of Mead in his writings on communicative interaction (1934). This would form a basis from which to begin to understand the theory of complex responsive processes, which is a way of thinking about management from a social interaction perspective rather than a scientific one. Mead argues that human consciousness and self-consciousness emerge in the conversation of gesture (Stacey, 2007: 270). His work explains in detail how the attributes of being human arise in the social (ibid: 270).

Mead's view on communication is very different from my previous understanding of communication through a sender–receiver model, in which one individual makes a vocal gesture to another. The vocal gesture is received and translated. If meaning is not understood, the sender will continue to transmit until meaning is received as it was transmitted (ibid: 271). Mead considered that for one body to make a gesture to another body, this would evoke a response. The response itself would be a gesture back to the first body, evoking further response (ibid: 271). This is referred to as an 'ongoing responsive process' that Mead described as 'conversation of gesture'.

Gesture and response form part of the social act and cannot be separated because together they constitute meaning. Meaning is therefore located in the circular interaction between past (gesture) and future

(response) as the living present. Shaw describes the *living present* as a 'lived- in experience of presentness, to open up for serious consideration how conversation as communicative action in the living present is transformational of personal and social realities, of the patterning of identity and difference' (2002: 46). Meaning is thus created in interaction, so communication can be viewed as a social relational process (Stacey, 2007: 272).

Mead also argued that for individual humans, mind arises in the social act in communicative interaction (ibid: 273). Mind or consciousness is the gesturing and responding action of a body directed towards self as role-play and silent conversation. Society is the gesturing and responding action of bodies detected towards each other (ibid: 273). I think Mead offers an interesting perspective on communication, by emphasising that meaning cannot be attributed to continued one-way clarification, as in the traditional sender–receiver model: rather, meaning arises in the ongoing process of gesture and response that together form a social act. If this is the case, then the ways in which strategic directives are traditionally communicated in the NHS will always give rise to potential for uncertain responses.

Communicative interaction as a process of negotiation

Returning to my own perspective on organisation, the experience I encountered through training was that the sender–receiver model was part of the discourse for effective communication. In my narrative, I discussed the

fact that Priya was hoping to have some feedback from our conversation in order to gain reassurance that her feelings were not unreasonable. I was struggling to respond in a way that would provide this, but remained conscious of the need to uphold the importance of 'efficiency savings' and defend the organisation. Because I could not anticipate how the conversation would play out, this created tension for me. In Mead's perspective, meaning emerges and evolves in the negotiation of gesture and response, taken together with the potential for novelty. With a sender–receiver model, the conversation should have been straightforward – Priya would have continued to clarify until we both understood the same meaning; but this did not happen. I ended our conversation feeling dissatisfied as a result of the dilemma I found myself in. As the conversation progressed, I assumed different aspects of my relationship with Priya – friend, manager, colleague – and each aspect also played out as an internal dialogue.

Mead further argues that humans develop the capacity to take on the attitudes of others – a capacity that evolves and becomes generalised. This he refers to as the 'generalised other' (ibid: 275). My conversation and internal dialogue may be further understood by Mead's 'I–me' dialectic:

> The 'I' responds to the gesture of 'me', which arises through the taking of attitudes of the others. Through taking those attitudes, we have introduced the 'me' and we react to it as an

> ‘I’. The ‘I’ of this moment is present in the ‘me’ of the next moment. There again, I cannot turn around quick enough to catch myself… It is because of the ‘I’ that we can say we are never fully aware of what we are, that we surprise ourselves by our action.
>
> (Mead, 1934: 174)

A number of authors have proposed interesting interpretations of Mead’s work. For Griffin, ‘the “I” is always present in the moment of acting but is never given to experience’ (2002: 157); instead, he describes the ‘I’ as a known-unknown for the ‘me’ and that the ‘I’ emerges as a unity of movement, as a unity of process, in response to the ‘me’. Carreira da Silva interprets Mead’s definition of self as an ongoing social process with two distinct phases: the ‘I’ and the ‘me’ (2007: 5). However, Mead does not split these as phases; he simply acknowledges that they coexist. Remembering my conversation with Priya, according to Carreira da Silva the phase of self that remembers is the ‘I’. The phase of self that is remembered is the ‘me’. When I remember what I said, in the very act of remembering, the subject of self-reflection ‘I’ is always slipping into the past, leaving only ‘me’ as the object of observation. Both Griffin and Carreira da Silva agree that the response, when it becomes known after the act, can be a source of novelty and unknown.

This way of thinking helps me to understand why my thinking during the conversation was not static in any one phase. In my interaction with Priya, I understand that the past can change based on the different responses that emerge from the ‘I’ in the present moment of our acting together – a dialectical process. The phase of self the ‘I’ is forming and being formed both at the same time. My point is that, in taking a complex responsive process approach, meaning is not clarified but negotiated; a sender–receiver model is therefore not helpful in accounting for my experience, because it assumes that meaning will eventually be ‘received’ as intended if the sender just continues to offer clarification.

What seems a more feasible explanation for me is that both Priya and I were negotiating the meaning without any idea what the outcome of the conversation would be. I was trying to make particular the generalisation of organisational strategy to this particular situation at that particular time, but the way that I was thinking at any point in time was dependent on Priya’s response. At the same time, it informed Priya’s response; and vice versa. We eventually reached a point of shared understanding through our negotiation of meaning. What I think is important is that it highlights how dependent my thinking was on the interaction between both Priya and I; that each time, through gesturing and responding with one another, my thoughts would evolve.

Responding in a climate of uncertainty

The pace of change in releasing efficiency savings and the development of the ICO was being upped: it was clear that the new government would not relax their target of £20 billion savings across the NHS. As an alliance, in order to further reduce the management cost and make the required efficiency savings, services across both Durren and Wyth would now have to integrate where possible. An 'integrated care organisation' refers in this context to a merger that brings together different care sectors (Fulop et al, 2005). The consequence of this decision was to merge and streamline the management structure so that there would be fewer managers and they would be managing across the ICO.

Integration was happening across a range of clinical services. Where a service manager had left the organisation, their counterpart was now expected to assume responsibilities for the neighbouring service. This meant that a management cost saving could be made by disestablishing a post. I was relieved that my service was not affected, and my service manager colleagues within Durren probably felt the same as in each fortnightly meeting we waited to hear what further reductions and savings would be required. The directives changed frequently. I understood this, but it was still anxiety-provoking to watch fellow managers leave and not be replaced. As far as I was concerned, my services – and more importantly, to me, my position – were not affected. In reality, change was unavoidable. My next

conversation took place with my manager, Ivana, Assistant Head of Operations in Durren. With all the changes and movements happening toward integration, I was a little nervous to be invited to her office. She began with friendly conversation, but I suspected she was warming me up for the next piece of information.

Ivana informed me that she had had a quick corridor conversation with Peter, Wyth's Director of Operations, regarding dietetics: it seemed that Priya had handed in her notice. Of course I already knew this, as Priya had told me. I didn't reveal this to Ivana, but I did allude to the fact that Priya had mentioned something in passing about applying for other jobs. Ivana suggested that this might be an opportunity to do things differently, as they had done with the podiatry services: when the manager from one borough left, the manager from the other borough assumed overall responsibility. I had heard coffee room gossip on this. Ivana then asked me whether I had seen 'the e-mail' – to which I responded, 'What e-mail?'

Ivana turned her computer screen towards me and then commented that I had not been copied into the e-mail – sent to Ivana by Peter following their recent meeting to discuss the possibilities of merging the management of Nutrition & Dietetic services across the alliance. He had initially discussed with Charlie and Priya the possibility of upgrading Sue (Priya's deputy) to this role; but as management savings needed to be made, it made more sense for me to take on the overall management of the two services.

The Director was concerned that Charlie would now have spare capacity, but had decided that she could use this for some project work that was needed across the ICO. As I scanned the text, I was annoyed at having been left out of the loop. They were referring to me in the e-mail and I had not even been copied in. I felt totally excluded at this point; this dominated my thoughts to the point that I was inclined to resist Ivana's directives, whatever they were.

Ivana said the executive decision was for me to now manage dietetic services across both Durren and Wyth. Apparently I did not have to do a review first because the timescale was too short before integration day. 'Quite frankly, between you and me, the review took too long,' she confided. (I was thinking the same thing: six months to review a service, only to agree that integration was the best option!) She added that there were rumours that the dietitians in Wyth were a 'difficult bunch to manage'. Dismayed at this prospect, I started to protest that I had only just acquired physiotherapy six months previously and could not fit this all in. Ivana's response was for me to give up physiotherapy for Charlie to manage, because her workload would be lighter now that she would be giving up dietetics. 'It will even up the brief,' she said; otherwise, Charlie could be put in a vulnerable position.

I felt my anxiety levels rising. My initial thoughts were that I could not take on any more work. My portfolio was rapidly expanding. How could

I possibly fit in all the management? I had just acquired community physiotherapy services in April; now I was being asked to lead and manage dietetics in Wyth. I was annoyed that there had been no indications at executive management meetings that these discussions had been going on; but even more annoyed and upset that I had not been included in the e-mail communication, particularly when I would be directly affected. I voiced my concern. Ivana's response, for me to 'give up physiotherapy', tipped me over the edge and although outwardly I remained composed, inwardly I felt angry and wary. I did not want to appear difficult at this stage: I wanted to have some say in what I managed, and if I annoyed Ivana, this may have put me in a vulnerable position. I could not take the risk of verbally expressing how I actually felt; so I stayed silent.

The community physiotherapy service in Durren had just got used to having me leading their service for the last couple of months and I was making headway into this male-dominated arena. They had been feeling quite fragile at having lost their head of service, and were just settling down and getting used to me. I pictured myself telling them that I would now be handing them over to another service manager in Wyth, and I knew this news would not be welcome. It had taken time for operational services in both Durren and Wyth to get used to the idea of an alliance when previously they have been rivals. This suggestion did not sit well with me. At the same time, I was feeling extremely guilty about what was happening to Charlie.

We were in similar positions. I imagined that she had only just adapted to managing dietetics and was now being told by her manager that she would be required to hand this over to me. I had hoped that being included in management discussions about the future of dietetics would give me some sense of control, but soon realised that what was unfolding in conversation with Ivana was quite the opposite. I felt as though she was missing the point, and not seeing my point of view.

Phillip Streatfield's discussion of the paradox of control may help to explain what was happening during the conversation with Ivana: he describes being in control and not in control at the same time. Streatfield argues that from a complex responsive process way of thinking, management skills and competencies lie in how effectively managers participate in the process. They provide a way of thinking about what competent managers actually do to live effectively in the paradox of organising (Streatfield 2001: 128). In Stacey's interpretation of Streatfield, managers need to continue to interact communicatively, especially using conversation. Additionally, we would be better able to make sense of organisational activities if we understand that organisational life requires us to live with paradox (Stacey, 2011: 484).

This very much contrasts with my own organisational experience, where paradox is not accepted and where possible contradictions must be resolved. Streatfield provides a very plausible argument within the context

that processes of responding cannot be controlled through strategic directives and planning. His thinking allows one to engage further with Mead's views on communicative interaction and that meaning arising from conversation is formed by and is forming subsequent meaning at the same time. My next conversation reflects this point in understanding what affected decision-making for me in particularising intentions in situations of paradox.

Processes of responding and complexity

From the e-mail Ivana showed me, it seemed that the decisions had been made without involving me, with the assumption that they would go unchallenged. I think this is where strategic choice does not take into account that as human beings, we have feelings and emotions. These come into play when I act; and if I take up a complex responsive process perspective, meaning is negotiated, so there is always the potential for uncertain responses. I do not think Ivana expected to be challenged, and I certainly did not enter the conversation with the intention of doing so; authors such as Senge do not help to make sense of this kind of unexpected action. I was unhappy with the directive, and with how it had been conveyed; so I seemed to be initially resistant. Thus, strategic choice does not help me to understand my own experience of organisational change.

If I were to take Senge's view, which is to imply that management of non-linear change within a systems dynamic perspective can be overcome

by following his five points of successful learning organisations (discussed earlier), then I should have been in control of the processes occurring as a result of the changes within the organisation and the relationships between myself, Priya and the executive management team. However, the changes that transpired can in no way be described as linear. At the time, there seemed no logical basis for the decisions and choices made: the strategic directive changed, but not in line with any pre-determined plan. What I understand now is that they changed as a direct result of communicative interaction between organisational members responding to one another in conversation. Here, we can begin to draw analogies with Stacey's views on population-wide patterns of activity that are forming while at the same time being formed through our exploration and negotiation of meaning through conversation.

Prigogine and deterministic approaches to strategic directives

In contrast to Senge's theory, Ilya Prigogine, a Belgian Nobel Prize-winning physicist, challenges the notion of linearity. Prigogine's theory of dissipative structures describes patterns that self-organise in a dissipative system. These ordered structures appear spontaneously and not only maintain themselves in a stable state far from equilibrium, but also self-organise. When the flow of energy through time increases, they may undergo new instabilities and transform themselves into novel structures, growing more complex by exporting or dissipating entropy (a measure of

disorder) into the surroundings (Reilly, 1999). In a social context, Prigogine seeks to explain the existence and development of order in the world – as opposed to the ongoing deterioration implied by the second law of thermodynamics, which states that if something is isolated from the rest of the world, it will dissipate all its free energy. Prigogine does not view the world as static with occasional disturbances to the equilibrium, but as dynamic where change and transformation are associated with non-equilibrium systems. A complex network of non-linear system relationships would influence the evolution of these and random developments (fluctuations) that would create a new system configuration that cannot be pre-determined (McIntosh & McLean, 1999: 11).

Stacey's articulation of Prigogine's work (Prigogine, 1997; Nicolis & Prigogine, 1989; Prigogine & Stengers, 1984) is that

> a dissipative system is essentially a contradiction or paradox: symmetry and uniformity of pattern are being lost but there is still a structure. Dissipative activity occurs as part of the process or creating a different structure. A dissipative structure is not just a result but also a process that uses disorder to change, an interactive process that temporarily manifests in globally stable structures. Stability dampens and localises change to keep the system where it is, but operation far from equilibrium destabilises a system leaving it open to change.
>
> (Stacey, 2007: 194)

Prigogine talks about ‘bifurcation points’ in self-organisation. In contrast to Senge’s ‘leverage points’, bifurcation refers to all those moments where choice is possible – a choice that can lead to the self-organisation and emergence of something new. Within the context of physics and chemistry, bifurcation requires the system to be non-linear, and as far from equilibrium as possible. In a linear system, the effect of change is proportional to that change, so small changes will have little or no effect; whereas in a non-linear system, small changes can have a dramatic effect because the impact may be repeatedly amplified by self-reinforcing feedback. Thus, bifurcation essentially occurs when systems move from one stable state to a new one.

Prigogine’s thinking enables me to make sense of organisational dynamics and to understand from my past learning how I have held on to this notion of controlling change within the assumption that causality will follow some linear path: if I apply the right techniques and processes, somehow I will be able to determine the outcome. Prigogine’s views go some way to explaining that deterministic approaches cannot be applied to systems that are non-linear, but patterns can emerge through self-organisation without any pre-existing plan or framework. I accept to some extent Prigogine’s view; if nothing is determinable, how can we understand change through simple cause and effect? Yet if it is determinable, then what happens to creativity and innovation? For Prigogine, nature is about the creation of unpredictable novelty.

In my thinking, Ivana and the executive team believed that reducing management costs through streamlining service line structures would be the best way forward to optimise efficiency while yielding the savings dictated by government policy. If the messages were communicated effectively, then it would automatically be accepted and a pre-determined process would follow. From a complex responsive process perspective, I now understand that I am operating in a paradoxical dynamic of stability and instability of control. How the executive team, Priya and I play out the situation is not clear cut. It seems to me that we are all constructing a process as we go along, or particularising in the moment. So in this interaction, strategy will emerge. Priya's resignation may start to have more relevance if I think about it as a bifurcation point rather than a leverage point. In Senge's perspective, the implication is that Ivana and I can exert influence (control) that will lead to a predictable outcome, but I am resistant. In Prigogine's perspective, Ivana and I would have a choice to make, but whatever we decide the outcome will be unpredictable, as it will emerge and be formed by our own intentions and the intentions of others. How can control be exerted through strategic directives to plan something that I am arguing cannot be known or predicted? In negotiating meaning through communicative interaction, our thinking was forming while at the same time being formed – a paradoxical form of transformation in which, Stacey (2010: 66) describes as 'local interaction (self-organisation) between diverse

agents forming population-wide patterns (emergence) while at the same time being formed by those patterns'.

Taking a complex responsive processes perspective on decision-making

I was adamant with Ivana that I did not want to give up physiotherapy, and started to rationalise why I should keep this service. My argument was primarily that the senior management structure in Durren was very stable, with each individual managing more services than our counterparts in Wyth. I asserted that the diverse portfolios would enable Ivana to create managers and leaders better able to manage the uncertainty and take forward the strategies of the new alliance. This was based on the breadth of experience that came from managing a range of services, as opposed to just thinking unilaterally about a single profession. In my desire to keep physiotherapy under my management, I tried to convince Ivana that as the government was encouraging more integration with their clinical pathways, they would require managers who could think through a range of services being provided along that pathway of care, not just their own. Ivana seemed convinced by this argument, and began to consider how to support my position, progressing with this to the point where we were reaching an agreement in our thinking. Clearly, at this point we were negotiating meaning in particularising our understanding of the general directives to restructure and save money. This was in contrast to receiving a message and interpreting it in the way the sender intended. In response to making sense

together of our gestures, an emotive argument emerged that seemed to resonate with Ivana, who agreed that the physiotherapy staff did not deserve to be offloaded again as they were definitely feeling devalued.

It was left to Ivana to have a discussion with Charlie's manager. I did not really feel a decision had been made. I also felt that neither Ivana nor her counterpart had a clear idea of how to proceed; the mantra of efficiency was a general statement of intent, but not a 'how to' guide. In Ivana's interpretation of the situation, the COO wanted integration of services, but it was up to the operational managers to indicate how best to do this. Ivana and her counterpart were simply responding to a statement around integration, and a suggestion of what this might look like. I did not feel that I could argue further about taking on dietetics, not wanting to be seen to give an outright refusal. So I agreed to take over the service. In order to take this decision further, Ivana suggested that I should meet with Peter, Priya's and Charlie's line manager, to discuss how best to move this along. This way, it seemed, I would still have a chance to either make some choices myself or influence others' decisions.

Several weeks passed; having heard nothing further, I was unsure what to do next. Despite the executive team wanting to push ahead with integrating services, communication changes constantly. This can range from the DH's instructions on management cost savings and integrating organisations to more local needs to respond to further cuts in the budget

from our local commissioners (NHS Durren was carrying a large deficit of £34 million). I contacted Priya, who also knew nothing. It seemed that since her demotion she had lost her key communication link into senior management decisions in Wyth, and was having to rely on Charlie to pass down information. I knew Charlie was on leave, so I contacted Ivana to see if she had had any updates on the situation. We spoke on the phone and Ivana advised me to check my inbox, as we had both just received an e-mail from Peter. Sure enough, I had received a message addressed to Sue, Charlie, Ivana and myself, saying that the executive team still wanted to progress me as overall dietetics manager, but noting that Peter would need to spend some time preparing the dietitians in Wyth. It was essential to review the reporting structures, looking at optimising the roles of senior dietetics staff. Charlie had been asked to carry out this piece of work. It was clear that I was not to be included in these discussions, although I would be kept abreast of what was happening. At the end of the e-mail, Peter requested a meeting with Sue and Charlie to develop the plan further.

I felt angered by my exclusion from this whole process. Although I knew I would eventually be expected to manage dietetics across the two boroughs, I thought I should at least have been included in the discussions around reorganisation of the Wyth structures; but this e-mail seemed to suggest that Charlie would now be overseeing this process, with me acting as an advisor. I felt powerless, especially as I would not be privy to their

ongoing discussions: Charlie was back in the game, and I was out. How, I wondered, could this approach facilitate integration? I visualised a situation where the restructuring in Wyth would not go well, then the executive team would pull out once they realised this, and I would be left to pick up the pieces of a resentful service. I worried that this would make it difficult for me to be recognised and accepted in Wyth.

No one seemed to have a clear idea of what their roles were or how to proceed: I had expected clear levels of executive decision-making, but the executive team appeared to be waiting for such decisions to come from the middle managers. What becomes apparent is that by understanding strategic directives and decision as ongoing patterns of activity, we come to understand how these cannot remain static or fixed, as we assume they do. They change and evolve through communicative interaction of gesture and response, where meaning is negotiated through our interplay of intentions. In this situation the interplay of intention underlies a power dynamic, which had an effect on the way that both Ivana and I interacted with one another.

At this point, I would like to briefly draw on the thoughts of Norbert Elias in thinking about how the dynamic of power affects the way we negotiate meaning. Elias proposes that power is a central characteristic of every relationship. My first project raises the issues of my assumption that power is located within the individual. What I have subsequently come to understand, through thinking in terms of complex responsive processes, is

that it arises from interdependent interaction with others. The dynamics of power occur from human activities, which both enable and constrain one another's actions – such as including and excluding, gossiping, and stereotyping. Ivana and I had our own different views on how we needed to progress the integration for dietetics. This dynamic shifted when I offered a counter-argument within the context of organisational development, which Ivana eventually accepted. When I subsequently found out that what we had agreed had now been overturned, based on an e-mail conversation from which I had been excluded, I was naturally annoyed and upset. In trying to understand what was happening around particularising general directives, complex responsive processes offers an alternative view to both Senge and Prigogine.

Inclusion and exclusion will be explored in greater depth in Project 3; but in this project, it is useful to draw attention to my thinking now around decision-making. Earlier, I identified my organisation's ideology as that of a learning organisation, in that there was still an expression of shared vision; common purpose; team working; and creating a sense of togetherness or being a 'part of' the organisation. So exclusion and inclusion is an everyday occurrence, with people forming groups either on a professional basis or from a management or operational basis. From the perspective of complex responsive processes of relating, these activities would be considered as enabling and at the same time constraining. So as a

middle manager, I felt a sense of belonging to a group of managers; but also a sense of belonging to a professional group.

Belonging can be enabling, but at the same time constraining – just as I uphold the ideology of the organisation, while at the same time the ideology of the profession and the views of frontline staff. Stacey articulates this well:

> Enabling and constraining activities also always reflect the choices people are continually making as they select one action rather than another in response to actions of others. They make choices often unconsciously on the basis of evaluative criteria provided by ideology. Such evaluative choices are simply another term for decision-making.
>
> (Stacey, 2011: 396)

It seems to me, therefore, that the evaluative criteria was as interpretation of ideology around efficiency saving. Decisions were not made on any formal basis. I was still expecting decisions to be made at the top, because that was how my organisation was structured: decisions seemed to be made based on personal preferences and corridor conversations, by those who considered themselves to have influence (and I include myself in this). I am not expressing negative judgement of this process, but these relational interplays of intention are not normally recognised as legitimate forms of strategising; yet they do influence people's views and thinking.

In complex responsive processes, decision-making is understood primarily in terms of ideology, power and social processes (ibid: 396). Strategies appear to emerge from ongoing emotional communicative interaction in which power dynamics shift through the interdependent relationships of individuals rather than through any methodical, rational and logical approach (ibid: 396).

Conclusion

My question for this paper was: What are the processes middle managers engage in to interpret what the initiatives and changes mean in their specific situations, as a basis for carrying out the instructions presented by executive managers who are in turn responding to government policies? What I understood at the time was that the messages themselves were as important in influencing the process as key individuals such as myself. This coincided with mainstream management ideology, which promoted a way of succeeding in organisational change by ensuring effective planning and communication and emphasising the role of leaders in influencing organisational change. In my discussion, I present mainstream management theory as influencing the way executive managers design strategy. This has the intention of controlling the process of planning and communication through systematic approaches that rely on middle managers to ensure strategy directives are carried out. Challenging this, I examine the theories

of complex responsive processes to offer a unique way of understanding the significance of the relational aspects of management.

First, I argue that implementing directives leading to change is by no means straightforward. Even with systematic approaches that have clear implementation plans in place and the right people involved, the desired outcome may not be achieved due to the unpredictability of people's responses. The process of responding to change in our daily encounters is dependent on the relational aspects of our interaction with others. This in turn is dependent on how each of us makes particular generalisations; in this case, strategic directives. Individuals will particularise in their own way. Acknowledging that organisational life is paradoxical in nature, decision-making in this context can lead to situations of dilemma and double bind, which in turn generate conflict and thus the potential for unpredictable responses.

I go on to propose that traditional communication based on the sender–receiver model approaches are unhelpful in understanding the processes of responding to change. In drawing attention to complex responsive processes, we perceive meaning not as something that is clarified through conversation, but rather as being negotiated through our action of gesturing and responding simultaneously with one another. Meaning from conversation is simultaneously both forming and being formed by subsequent meaning. If we think about strategy as population-wide patterns

of activity, then we can use this analogy to understand that strategic directives are not sets of instructions that are immovable and unchanging: they are forming, while at the same time being formed through, our exploration and negotiation of meaning through communicative interaction and the way that we particularise.

Finally, I argue that one cannot exert control nor apply deterministic reasoning to population-wide patterns that are continually transforming. This is because they emerge from ongoing emotional communicative interaction in which power dynamics shift through interdependent relationships of individuals. This both enables and constrains activities, which in turn affects choices and decisions.

In my next project, I look forward to making further links to communication and themes of inclusion, exclusion and power relationships in the translations of government policy into local strategies.

Project 3

How middle managers in the NHS respond to translating policy into practice; and the experience of resistance

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Background to government policy: Transforming community services

In January 2009, the government published its policy guidance *Transforming Community Services: Enabling New Patterns of Provision* (NHS Manchester, 2009). This document was intended to provide support for NHS organisations in England to decide on future arrangements for provision of community services. It provided advice on different organisational forms and how to manage the change to support service transformation. Later that year, the government set out its five-year plan to reshape the NHS to meet the challenges of delivering high-quality health care in a tough financial environment. The vision for the NHS was that care would be organised around patients – whether at home, in the community or in hospital. The ambition was to deliver cost-effective high-quality care across all services.

> We will greatly increase the integration of services by doing much more to shape them around patients and to ensure the boundaries between organisations do not fragment care. Community services will be a particular priority, since they

> have a pivotal role to play in realising the vision for more integrated, efficient and people-centred care.
>
> (NHS Manchester, 2009)

NHS organisations were given choices on the organisational form they wished to take. There were three options: to integrate with a hospital or with another community provider, or to form a social enterprise. It was clear that the purpose of this integration was to reduce management costs, promote innovation, provide better quality and experience of care for individuals, and improve the efficiency of service (DH, 2009: 4). My organisation (NHS Durren) took the decision to integrate with another community provider, NHS Wyth. Both executive teams made the decision not to call this a 'merger', but to give staff the message that we would be forming an 'alliance'. By forming this larger critical mass, efficiency savings could potentially be made from economies of scale.

At a local level, this was further translated as integrating services and streamlining the management structures. The implications for this were great for staff, who feared their services being eroded or replaced. Community services were threatened as integration began to take place. However, the way in which government policy was being interpreted at a local level by the executive management team was continually changing, which made it extremely difficult to adhere to communication and implementation plans: we would be told that no one would be made

redundant through restructuring processes, only to be told later that redundancies were the only way to meet cost reduction targets.

By mid 2010, the government changed policy once again: community providers were now urged to integrate with a local district general hospital, to create an integrated care organisation (ICO). The newly formed alliance between NHS Durren and NHS Wyth would now merge with the Allwyn Hospital by April 2011.

Integrated care is seen as a concept that removes the artificial boundaries between hospital and community services. The intention is to bring together provision of care, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion (Gröne & Garcia-Barbero, 2001). The new ICO would be called Allwyn Medical; it was seen as the answer to improving continuity of care for patients when they were discharged back to their home. For the purposes of this project, I will only make reference to the 'alliance' between NHS Durren and NHS Wyth; integrated care will be discussed in detail in Project 4.

To achieve a single management structure, the alliance required a radical restructure of all management posts from senior middle management upwards within a given time period. This inevitably caused a high degree of anxiety as all the managers jostled to position themselves in readiness for 'integration' while at the same time wondering if their jobs might be cut. In

Project 2, I made reference to the strategic directives planned by the community executive team: to achieve cross-borough integration, each organisation needed a plan of how it would contribute to both local and national savings targets. This strategic position changed within the same year to prioritising financial savings. Not only would community managers be subject to restructuring, but there was likely to be a further restructure with hospital managers to yield the required savings. Despite the urgency of these changes, it was acknowledged that there should also be an adequate time period in which to consult with staff as each individual community service was identified for integration. As the executive teams were still in formation, it was left to the senior middle managers to implement the process of integration and restructuring, without knowing themselves whether they would have a job in the new organisation.

This project will be a narrative-based inquiry, focusing on my relationship with a physiotherapy manager and our responses to the strategic position resulting from higher-level planning where organisational restructuring formed part of a process for integration. If I look at this as an example of patterns of action found more widely in NHS in which I see an ideology of control; the imposition of having to conform to and uphold the strategic position during times of organisational change, shifts patterns of power relations and can threaten identity. This has an effect on how we behave, particularly when managers themselves are expected to manage

change processes but at the same time experience threats to their own position within the organisation.

My research question follows on from Project 2, where I argue that processes of responding to strategic directives are dependent on the relationships between middle managers in their day-to-day interactions. I refer to strategic directives as abstractions that result from the way we make particular, at a local level, the generalisations that are interpreted as government policy. This project questions how middle managers respond to translating government policy into practice and experience resistance. I seek to understand how I struggle to come to terms with conflicting thoughts regarding the processes of restructuring. I want to explore how middle managers view themselves within the organisation, and what effect this has on power relationships with subordinates. I am further interested in how patterns of behaviours in the forms of resistance play out in local interaction in tacit and explicit ways. I propose that we should rethink the way we perceive the role of middle managers as change agents, and that being sensitive to organising processes such as resistance may be a better way of looking at initiatives to support integration.

Middle managers in the NHS

In trying to understand my relationship with other organisational members, it may be helpful to first understand how I perceive my position within the organisation. This provides some context for my level of influence, in terms

of the traditional management discourse. Alistair Hewison examines middle management in his book *Management for Nurses and Health Professionals* (2004). He surmises that there seems to be little consensus in defining what it is that middle managers do but the emphasis is always on role, responsibility and task. Other authors have also followed this line of thinking:

> Middle managers integrate the organisation as a whole or various parts within the organisation. They transfer materials to different parts of the organisation and co-ordinate organizational activities.
>
> (Schlesinger & Oshry, 1984: 8)

> In general, the purpose of middle management is to take responsibility for and control the managerial problem. As Boundary spanners, middle managers mediate between organisation and its customers and suppliers. As administrators, middle managers direct the organisation to the overall task.
>
> (Floyd & Wooldridge, 1997: 466)

> Middle managers modify the implementation of deliberate strategy. They are purveyors as well as recipients of change.
>
> (Currie, 1999: 141)

All of these definitions arise from characterisations of an organisation as being made up of layers of management structure. My role at this time was that of senior manager, but as we started to integrate line management and certain roles and functions disappeared, it became increasingly difficult for middle managers to have a sense of what their responsibilities were within the changing organisational landscape.

Hewison is clear that in health care, middle management roles have become increasingly significant, which has resulted in a change in structure and flattening of hierarchies. He suggests that one way of characterising their work is partly as a means of resolving conflict, which he states could be between professional and managerial concerns and priorities in the way that work is conducted. He also says there may be internal conflict as individuals attempt to integrate the values and aims of management into the professional value set. He concludes that middle managers must decide themselves how to cope with these transitions (2004: 133). This was certainly my thinking at the time: I believed that the actions I took were my responsibility, and that I needed to define my changing role within middle management. However, my levels of autonomy around decision-making were also changing: I had to defer to decisions from the executive team, just as my service managers had to defer to mine. As I will explore in greater depth, conflict arose as a result of service managers feeling they had less

influence. The delineation of roles became blurred – perhaps especially between myself and the service manager for physiotherapy.

Hewison argues that the ‘plight’ of middle managers is one of more devolved responsibility, having to cope with conflicting expectations and loss of technical expertise (2004: 126). He stresses the importance of understanding the role of middle managers more fully through the recognition of role and the level of influence the individual can have within the organisational structure. It is quite clear from authors such as Hewison that this sense of role is clearly linked to the identity of individual managers. In essence, my understanding of my role was that of a position of influence, which carried a sense of autonomy, power and control over the groups I managed. My assumption was that power was inextricably linked to the middle manager’s role; and that the higher up the hierarchy, the more such power and control a manager would have.

Local interaction between middle managers

I acquired the physiotherapy service in April 2010. I was given the brief to caretake this service for an interim period, while the management structure was revised in readiness for possible integration. This would mean I would be directly managing the physiotherapy manager, Jack, who had previously been managed by one of my colleagues. The physiotherapy service was seen as offering potential to yield financial savings by redirecting care for patients away from the hospitals and closer to home, in the community; but

this would require physiotherapists to change the way they practised. They would need to start engaging with their colleagues in both Wyth and the Allwyn, and working with evidence-based practice.

I was apprehensive. The physiotherapy service in Durren was seen as a strong team; they had never been led by a senior manager who was not a physiotherapist. It was an extensive service, with over 40 members providing care in hospital outpatient settings as well as community clinics. I understood from my manager, Ivana, that they were clinically very competent; but she felt that they were ‘inward looking’ and needed to be more ‘outward looking’. She was also exasperated by continuous e-mails from the physiotherapy manager suggesting how to take the service forward, which did not take account of the strategic direction of the organisation.

In trying to arrange a meeting with Jack, I waited several weeks for a response. Having been operational lead for the last two years, Jack felt he had a degree of autonomy to make decisions. When we finally met, he was polite and professional; but I sensed a ‘command and control’ attitude. Physiotherapy at the time was male-dominated and hierarchal, in the sense that there was a chain of command and everyone knew whom they reported to. No junior staff member was given any freedom to act. Jack appeared to control every piece of communication that went in and out of the service.

It soon became clear to me that Jack preferred to communicate through e-mails; it also became apparent that he wasn't the only one in charge of the physiotherapy service. Jack had a deputy, Jim, who tended to take care of all the operational management even though Jack and Jim were working at the same organisational level. Struggling to understand the differences between their roles, I felt that Jim was comfortable with talking to people, whereas Jack referred to himself as a strategist, preferring to develop policies and procedures and pathways of care on his own; Jim would be the one to operationalise these. I found myself referring to them as if they were the same person. It was clear they were having difficulty recognising me as their manager: they would often go straight to Ivana, my line manager, for any decisions. They had enjoyed a period of freedom to make decisions and be involved in higher-level strategy. The executive team were encouraging managers from similar services in their neighbouring boroughs to work together to develop pathways of care that could be integrated. When I communicated this to Jack, I found that he and Jim had already worked on a plan between themselves. Indeed, they had been e-mailing my manager Ivana with their ideas, without copying me in – a bypassing that frustrated both me and Ivana. I felt undermined, and was irritated that they were ignoring the chain of command.

Subgroups within middle management

I decided to set up weekly meetings with all the junior managers who reported to Jim. In the beginning, Jack would attend these meetings but offer little engagement; in the end, he stopped coming to them (the reasons for which will become apparent). This came as no surprise to the junior managers, who would often describe Jack as a private and shy person – great at strategic thinking, but lacking ‘people skills’. They seemed to overlook his non-attendance, even making excuses for it. However, Jim would attend and often act as Jack’s spokesperson.

These regular meetings were very productive. When Jim and Jack both attended, the junior managers seemed more guarded in their discussions, often deferring to either manager; in their absence, it was a completely different atmosphere. Reflecting back on those meetings, I surmised that this group of junior managers had many ideas and ways to improve the service and take things forward, but Jack and Jim always blocked them. This happened so frequently that eventually the junior managers gave up and would just defer every management decision to Jim. Although they seemed to have great respect for Jack, they spoke about their frustrations at not being given greater autonomy. They wanted to be challenged; they wanted an opportunity to influence the organisational changes, rather than just being told what to do and when to do it.

Some of the team had had an opportunity to meet with Charlie, the physiotherapy manager in Wyth, at a previous event. They liked her. She was easy to talk to, friendly, and – more importantly, for this team – approachable (something they had always found difficult with Jack). They didn't foresee any problems with working with Charlie and her teams to look at care pathways for patients. They were positive and saw this as an opportunity to showcase their talents and skills; at last they had permission to use their own initiative – which one junior manager described as having the 'lid lifted from the tin'. However, it was noticeable that when Jack and Jim did join us in these meetings, the dynamics and free flow of conversation changed. We all seemed less animated, more controlled in our conversation and choice of words, less relaxed.

I would often get desperate e-mails from the junior managers telling me how difficult it was becoming to work in the environment, as Jim and Jack were constantly negative about the strategic direction. One of the junior managers said it felt as if they were not supportive of the integration, but were 'attempting to sabotage any of the junior managers engaging with the process'. I gather that Jack and Jim often made snide comments or belittled any ideas the junior managers had. The junior managers, in turn, were becoming quite despondent. Every day, it seemed, one of them would call or e-mail me with anxieties that always seemed to start off with 'I'm concerned about Jack and Jim and how they are behaving'.

Shifts in power relations between groups of middle managers

In Project 2, I discussed the idea of belonging. The proposition is that to be a part of the group gives me a sense of belonging and being needed. The need to belong is a very powerful impulse, fundamental to the way human beings organise themselves (Dalal, 1998: 177). If we consider how this sense of belonging both enabled and constrained me in relationships with the junior managers, we can see how I wanted to establish myself as part of the physiotherapy team. We seemed united by our common perceptions of Jack: we had established difference between him and us, and were excluding him. Dalal points out that this is one of the principal ways in which power differentials are preserved: it is not the difference itself, but rather the ideological form of it, that stirs up hatred in the interest of sustaining power positions in a dynamic of inclusion and exclusion. Although I doubt that any of us were motivated by hatred, we were certainly united in our perceptions of Jack's behaviour toward us: he was framed as the enemy. I felt like their newly appointed leader who would protect them against Jack. This fantasy that we constructed together strengthened my bond in the group.

To understand the dynamics of inclusion and exclusion, I firstly need to provide some explanation around power relationships. My thinking prior to the DMan programme was very much that power was located in the individual (certainly my own experience of both the medical and

organisational hierarchy), who – with the right structures in place – could control and shape the outcome. For sociologist Norbert Elias, writing in *The Society of Individuals*, power is not a force that individuals possess but a 'structural characteristic' of all human relationships, reflecting our dependence on one another. It is an activity of enabling and constraining one another, and is based on need (Elias, 1991). However, this power is not definitive: one can only be viewed as having power through the recognition of someone who is less powerful.

In my dealings with Jack, I assumed that as I was in a position of authority, I would be the more powerful. However, in reflecting on his demeanour towards me, I assumed he was having difficulty adapting to recognising me as his manager because he had had a brief period of time where he was directly reporting to Ivana. I needed Jack to approve of me. This view draws attention to the fact that power is not a force within individuals, but differential and relational; and that the relational aspects both constrain and enable at the same time. Group analyst Farhad Dalal, in his book *Taking the Group Seriously*, uses the analogy of power figurations in relation to group in order to describe interdependence, suggesting that this is 'as though we are attached to one another by a series of elastic bands' – a comparison that illustrates how our actions are constrained by the other (Dalal, 1998: 88–89). He describes this as an unconscious process where

differences in the group emerge from local interaction as patterns that are not often intended by any one individual.

Foucault and Elias on power relations

To further understand the concept of power as relational, we also need to understand that differences in power are dynamic. French philosopher and theorist Michel Foucault, by rejecting any reification of power, shares Elias' view that power is not located within the individual, asserting that 'power is everywhere not because it embraces everything but because it comes from everywhere' (Foucault, 1998: 93). I have drawn on these views in seeking to understand my relationship as a manager with Jack, Jim and the junior managers. Foucault was interested in thinking about new ways of seeing knowledge and power. He sought to demonstrate how closely the emergence of knowledge – associated with the sciences of mental health, medicine and sociology – were enmeshed in the problems of practices of power, social government and management of individuals. Foucault sets out to show that in recent history, the knowable individual is one who has been caught in power relations as someone who is to be trained, supervised and controlled (Foucault, 1994: xvi). I could see there were similarities in what Foucault was discussing and my ideas of what it was to be a manager and the experience of power relationship between these individuals.

My ideas on what a manager did were very much focused on how to supervise and control my subordinates – something that seemed to depend

on how much each individual was conforming. Jack and Jim did not recognise my authority, so I felt I needed to exert more control; whereas the group of junior managers did recognise my authority, so I viewed them as more cooperative. The more I constrained Jack and Jim, the more enabled they were to resist; the more I enabled the group of junior managers, the more they may have been constrained to resist.

Foucault believed that rather than power being situated in the act of relating between people, it is distributed throughout complex social networks that establish or reinforce connections between what dominant agents do and the fulfilment or frustration of subordinate agents' desires. Foucault seems to describe power relations in the context of oppression, as something that moves between the dominant and subordinate. The more the dominant exercises power, the more the subordinate will react in particular ways.

Foucault's main concern with power is with particular circumstances and how power is exercised, whereas Elias describes power through his articulation of interdependence as 'game models' that are interwoven. Elias sees all relationships between human beings and their functional interdependencies as processes, and the term 'interweaving' points to the processual nature of such relationships (Elias, 1998: 120). His view is that power is intrinsic to all human relations, and that it is the power differentials that primarily drive situations. This is in contrast to the way I was thinking

at the time: I still felt that I could control or influence the relationship between Jack and myself, and that if only he could understand my point of view then we could reach some point of shared understanding. I felt that this was something that I alone had to contend with: only I could determine how Jack and I would work together. Since I was the manager, this was my responsibility.

If I take on Elias' way of thinking, I now come to understand that in organisations, even though there is a hierarchy and forms of domination through structure, there is no absolute power of control that any one person has over another. Power has to be understood in the context of relationships: the interdependence of the relationship between myself and Jack, and myself and the junior managers, both constrained and enabled us to a greater or lesser extent through these interweaving processes. This is not fixed at any one point in time, but a continual dynamic process occurring in our day-to-day interactions.

Elias uses game models to describe how power is intrinsic to all human relations precisely because of our interdependence on one another. I find his game analogies useful in understanding the complexity of relationships that exist between players or organisational members. For example, if there are two players, one with greater ability, then that player will be able to force the other player's moves and ultimately dictate the course of the game. As I reflect back on the relationship between Jack and

myself, this is how I felt: that I could shape the outcome. A further model considers two players both of similar ability, meaning that each player has less chance of manipulating the other. Elias says that this results in a 'game process' that neither has planned, and that this game process may go some way to resembling social process (1978: 82). The other varieties of game model become more elaborate and intricate as the number of players increases and have various degrees of strength. This makes the process of game increasingly uncontrollable and unpredictable by any one individual; but, more importantly, each player becomes controlled by the process of the game itself. A game process that comes about entirely as a result of this interweaving of the individual moves of many players takes a course that none of the individual players has planned, determined or anticipated. On the contrary, the unplanned course of the game repeatedly influences the moves of each player as they engage in it (Elias, 1978: 95).

The dynamic of inclusion/exclusion in relation to identity

I made reference earlier to the way a middle manager's role is linked to their identity. I've also discussed how power relationships are dynamic, and are paradoxically enabling and constraining at the same time. I now aim to explore how these changes in power relationships can be perceived in relation to identity. In making sense of the relationship between Jack and myself, I experienced a push/pull tension that was both enabling and constraining us. Using Elias' analogy, we were caught up in a social process

('game') that was beyond either of our control and included other organisational members – all of whom were also enabling and constraining in their relationships with one another, and with us, through these interweaving processes of responding to the organisational strategy. This interdependence would make it difficult to plan, determine or anticipate how Jack and I might respond to one another.

In organisation, the game process influences us, as demonstrated by the way we make generalisations such as in policy or strategic directives. As individuals, we interpret these generalisations and make them particular to our own situations. I cannot control this game process – not only because of my mutual dependence and positioning as a player within the group, but also because of the tensions and conflict that are inherent in interweaving organisational relationships. Stacey views conflict as inevitable: individuals will differ in the way that they particularise these generalisations:

> Through conflict we carry on exploring and negotiating the meaning of generalisations; and it is this conflictual explorative process of particularisation that makes possible further evolutions of generalisations as tiny variations in the particular way the generalisation is taken up and amplified across a population over time.
>
> (Stacey, 2010: 355)

Differences in the way that organisational members particularise are dependent on power relationships; according to Stacey, differences in power establish groupings by which some people are included and others excluded.

If I relate this back to the situation between myself and all the physiotherapy managers, I can begin to understand how the differences in power relationships established subgroups, giving rise to both inclusion and exclusion. At times I felt like an outsider: I was not a physiotherapist, only a senior manager. However, organising the regular junior managers meetings, I wondered at what level I would be recognised; and it soon became apparent that I had some sense of identity with the junior managers, who were all women. At this level, there was a clear distinction between the men (Jack and Jim) and the women. Being a new manager to this service, I wanted to feel a part of this group; I needed to have a sense of belonging and to feel a part of the team. Stacey suggests that 'power refers to this fluid pattern of perceived need and expressed figurations of relationship. These figurations are social patterns of groupings in which some are excluded' (Stacey, 2010: 181). I felt excluded from the 'group' of Jack and Jim, but included in the group of junior managers, who also at the time felt excluded from the group of Jack and Jim. So although I was unconscious of this pattern at the time, as I reflect back, the junior managers and I had something in common in our exclusion from Jack and Jim. I think I quickly formed an attachment to them. Dalal uses Elias' process of game to explain

that such attachments can be linked to loyalties, which become a strategy that increases the chance of winning; but that the emotional and psychological elements of strategy are always unconscious.

Elias and Scotson (1994) illustrate the dynamics of inclusion and exclusion in their study of a town ('Winston Parva') in Leicestershire. This town consisted of an estate built next to a village and what they noticed was the differences between the two communities of estate dwellers and villagers. The identity of each group was created and sustained through gossip. The villagers, by virtue of their longer-standing established community, were negative about the estate dwellers, and the gossip about one another polarised the two communities into 'good' (the villagers) and 'bad' (the estate dwellers), sustaining patterns of power relations. The villagers' stigmatisation of the estate dwellers became a self-perception of the estate dwellers; this further preserved the superiority of the villagers, who had created a 'we' identity. Stacey (2010) extends this view to say that ideology provides criteria for choosing one action over another, serving as an unconscious basis of power relations so that it feels natural to include some and exclude others from particular groups, thereby sustaining the power difference between them.

Connecting these views, I would suggest that my own actions and those of the group of junior managers enabled the 'we' as a group to form an identity together; at the same time, this constrained Jack and Jim – who,

at the same time as being excluded from the group, also excluded themselves from it. These actions were not just those of Jack and Jim excluding themselves from the 'we' identity, but were also ones where exclusion was simultaneously co-created through my relationship with the junior managers and our interdependence on one another, both as a group and as individuals, and interdependence between the group and individuals in relation to Jack and Jim. What is of interest in the broader context of organisational life is how we, as a group of middle managers, further subdivide ourselves through this process of inclusion/exclusion, which we are all co-creating through our interaction with one another.

In organisations, we seldom acknowledge these subgroupings, which arise from polarised views; yet they represent further differences that affect the way we make generalisations particular in any given moment. I have found (such as with Jack and Jim) that this lack of understanding and sensitivity to these organising processes can hinder local interaction, which – as we shall see – can lead to an amplification of defensive behaviour in the form of resistance.

My experience of tacit resistance

Unconsciously, I made assumptions that Jack was a difficult character, and included Jim in this categorisation because of his close alliance with Jack. In attempting to manage the task of implementing the strategic directives for physiotherapy, we were to have some initial discussions with NHS Wyth

physiotherapy service, with which we would be integrating. The executive team were directing all middle managers involved in implementing change to set up stakeholder meetings with affected parties, with a view to encouraging 'ownership' of the integration. 'Ownership' is viewed as part of an organisational change management process (Kotter & Schlesinger, 1979). Kotter and Schlesinger believe that if staff feel they have ownership of organisational change, then they are less likely to resist change. An initial meeting was arranged for all stakeholders to begin discussions around a new integrated care pathway that would be increase efficiency and productivity. A number of senior people attended the meeting – including a commissioner and a lead rheumatologist, as well as other physiotherapy colleagues from our future ICO.

Jack and Jim, who seemed to view the other physiotherapists as competitors, were reluctant to share their work and ideas; but I had persuaded them to cooperate in the interests of finding solutions for integration of patient care. I tasked Jack with presenting some innovative pathway ideas he had developed. I invited Jim along to bolster Jack's confidence in presenting these ideas; he reluctantly agreed. I had an agenda, and saw this as a chance to showcase some of Jack's thinking – not to mention an opportunity for him to start gaining some confidence in presenting and engaging with other senior personnel and professional colleagues. I managed to convince Jack that we had a good model and that

others would be keen to see what he had achieved. My intention was to show a united front in terms of the work we had been doing, and demonstrate that we were a strong team committed to service improvement and clinical care. On reflection, I was assuming an identity that was not shared by Jack and Jim.

Arriving at the meeting, I found Jack and Jim deep in a conversation that stopped abruptly the minute I joined them. We shared a few minutes of general discussion, although I was conscious that I was mainly talking to Jim. However, I had confidence in the work they had produced and they were both positive about it. Charlie was the next person to appear. The head of physiotherapy in Wyth, Charlie was also the interim manager for Nutrition & Dietetics; we had worked together for some time on moving this over to me. She knew of Jack and Jim, but had never met them in person. I introduced Charlie to Jack, and Jim greeted her. I then began to open another conversation; at this point, I noticed that Jack and Jim had ceased to engage directly with Charlie. I thought this was odd, but at this point I ascribed it to shyness and the fact that they had once viewed Charlie's service as a competitor.

Ivana arrived and introduced everyone, then asked Jack to present his ideas. As soon as he had finished, everyone naturally had questions, which they directed at Jack. We all waited for him to engage in the discussion and explain his rationale; but he gave only a brief reply – then

looked at Jim, who also remained silent. Anxious to relieve this awkward gap, I made some general comment and invited Jack to respond; but he remained uncommunicative. I was embarrassed by their lack of participation, and saw them as deliberately excluding themselves from the discussion. My notion of presenting a united front was collapsing, and I had no sense of control. Fortunately, Charlie came back with some response on practice in Wyth, and conversation started to flow; but it was still clear that Jack and Jim were unwilling to engage. They sat through most of the meeting contributing very little.

Jack had done a good piece of work, which I wanted to support and defend; but we were clearly not working together. Ivana later commented that Jack had produced a good piece of work, but it was a shame about his performance during that meeting. She had noted that neither Jack nor Jim had contributed, and that for most of the meeting they had remained silent. She was unhappy about this and concerned that Durren's physiotherapy service would not been seen in a positive light. She expressed the hope that I would address this when I next met with Jack.

I had to confront the problem. At first, I had been angry that Jack and Jim were unsupportive of the process to engage in a care pathway. I was also embarrassed that Ivana had picked up on their lack of participation, which made me feel as if I was not managing them properly. I needed to confront both Jack and Jim about their apparent collusion to sabotage any

plans to integrate services. I arranged to meet with them both to try to resolve this problem. I was apprehensive about the meeting. I needed them to start including me into their conversations around developing care pathways; I also wanted to ensure that they would start to engage with other physiotherapy managers to look at ‘best practice’. At the same time, they seemed to be aware that they could be potentially sabotaging efforts to integrate the service.

When they arrived, I was surprised to find Jack quite chatty. I started off praising his effort to produce a really good and innovative model of care for patients; then talked for several minutes about how they felt the meeting had gone. They were negative about Charlie’s presence; I responded that I understood her service in Wyth had a very good reputation. Jack and Jim did not seem to welcome this information; perhaps they felt somehow alienated and excluded by my efforts to be inclusive of Charlie’s service. I outlined Ivana’s plans to implement the strategic directive to integrate models of care in Wyth and Durren. Jack responded, ‘Why do we need to work with them? It’s our model, and we know it will work well in Durren. We don’t need to share’. I felt the need to get Jack to understand that we would all eventually become one organisation and that it would benefit patients to start sharing good practice across a larger geographical area. I was trying to articulate an organisational view of integration, which was an

abstraction. Jack replied that in the past, other services were seen as competitors; there had never been any need to be friendly.

Throughout this exchange with Jack, Jim had remained silent; but suddenly, he spoke: ‘Why do we need to change? It was all going well until management decided to make changes’. Jim made the point of referring to ‘the management’ – presumably Ivana, the executive team and me. The way he kept referring to ‘the management’ made me think that he and Jack viewed themselves as somehow separate from the middle management structure. What I came to understand, through the theory of complex responsive processes, is that such a reference to ‘the management‘ is *reification* – ‘a process in which people project meaning onto the world and then perceiving those meanings as existing in the world and having a life of their own’ (Stacey, 2011: 218).

Jack and Jim viewed themselves as outside the ‘the management’, and this relates back to the dynamics of inclusion and exclusion. They did not recognise themselves as being included in this group; and they were unhappy about the prospect of integration. Jim expressed his lack of agreement with the ‘direction of travel’, as he put it, that we as an organisation were going through. He explained how he felt management were destroying everything that he and Jack had built up over the last few years, and that the organisation was only interested in saving money rather than improving quality.

Jack was completely silent at this point, and seemed to be deferring to Jim. I wanted to try and find a way that we could move on together, or at least gain some agreement on how we could start to engage with Charlie's team in Wyth; but all I could really do was listen to Jim without opposition. Although Ivana had asked me to address their behaviour, it did not seem appropriate to do so now, when they were expressing dismay at the way they felt their service was being dismantled. I could see two very dedicated people who had developed this service in a particular way; now I was asking them to ignore all the work they had been doing and start again, working with me to implement a strategic directive that they did not support – and which I felt ill equipped to defend, given that in implementing it we would indeed be prioritising efficiency savings.

Understanding resistance in organisations

In understanding how threats to our identity can lead to resistance, it would first be useful to reflect on the way I was thinking about resistance at the time. Much of what has been written in management discourse regarding resistance to organisational change has been based on Kotter and Schlesinger's (1979) perspective. In an article for the *Harvard Business Revie*w, these authors described various causes of resistance to change – an interpretation that has been influential in most traditional management discourse ever since. Their view was that such resistance could be overcome through a systematic approach to selecting strategy and processes for

implementing organisational change. They based this information on various analyses of examples of what they describe as 'successful' and 'unsuccessful' organisational change. They concluded that if managers understood types of resistance and selected the appropriate strategies for managing it, then those processes – coupled with effective interpersonal skills – would greatly improve the chances of a successful outcome.

Bovey and Hede (2001) discuss resistance to organisational change from the perspective of resistance as a defence mechanism: they suggest that managers should consider it from a psychological perspective. They categorise behaviours associated with resistance and conclude that managers need to take human factors into consideration when choosing the appropriate intervention strategies, which can help the person resisting to have increase self-awareness, altering their perception of organisational change and reducing their resistance to it.

In thinking about organisational change through complex responsive processes, three points stand out for me. Firstly, these authors clearly view resistance from an objective observer position: they describe managers as though they are somehow removed form the process of relationships with staff. Secondly, it's clear that resistance is considered as an individual characteristic that can be influenced independently of any interaction. From my example of interaction with Jack and Jim, I would say that managers and staff have intentions to act, and it is this interplay of intentions that evokes

responses when we interact with one another. These evoked responses give rise to resistance. I would now question this notion that I could influence or control this process, because I was not external to it: interdependence means that we cannot separate ourselves out from the processes of responding, as evidenced by the thoughts and emotions that were evoked through our interactions. I would say that this is fairly typical of organisations. Thirdly, in management discourse there is an implication that resistance is something to be reduced, something that can be avoided or removed by the skilled actions of an individual. My intention to secure 'buy-in' to organisational change was part of the strategy of engagement; but it did little more than enable Jack and Jim to resist.

Resistance as a response

Tom Spiers (2007), in his PhD thesis on merging and demerging in organisations, proposed that mergers and acquisitions constitute a threat to social identity by disrupting long-standing patterns of relating between people. He points out that this is experienced as emotional anxiety, which is personally felt and collectively shared. He further states that in response, social defences are invoked to alleviate distress but simultaneously inhibit processes of recognition to effect identity transformation. Spiers refers to social identity theory, which Hogg and Abrams (1988) define as a person's knowledge that they belong to a social category or group – a social group being a set of individuals who hold a common social identification or view

of themselves as members of the same social category. Through a process of social comparison, persons who are similar to self are categorised with self and labelled *in-group*. Persons who differ from self are categorised as *out-group* (Stets & Burke, 2000). Here, we can draw distinctions between Elias' and Scotson's (1994) analysis of resident groups in Winston Parva.

Taking a complex responsive processes perspective, I can see that Jack and Jim had formed an identity, and now realise that in that initial integration meeting, asking them to just assume unanimity was asking them to do something they did not really agree with but went along with. This I now view as a disruption to their long-standing patterns of relating to one another and therefore a threat to their social identity. From an organisational perspective, this 'top-down' approach to changing organisational culture and identity by instilling new beliefs, values and working relationships is fairly typical of attempts to implement change management processes within the NHS. It is acknowledged that the defensive behaviour of disaffected individuals can be disruptive, so there is an expectation that staff need to 'buy into' any culture change initiatives. Spiers, however, seems to suggest that resistance is a response that is co-created rather than an inherent behaviour.

In his book, *Domination and the Arts of Resistance*, James C. Scott (1990) offers another way of thinking about resistance: as a normal part of local interaction. He discusses how people block, subvert and countermand

the categories that state simplification imposes. He describes power relations where the subordinates are often obliged to adopt a strategic pose in the presence of the more powerful, especially when the powerful are keen to emphasise their reputation and mastery. Every subordinate group creates out of its subjugation a 'hidden transcript' – a critique of power, spoken behind the backs of the dominants. The powerful, too, develop their own hidden transcript, representing the practices and claims of their rule. Scott argues that subordinate groups, by the same token, have self-interest in reinforcing the strategic pose (what he refers to as the 'public transcript') in order to conceal their 'hidden transcripts'.

Scott uses the term 'public transcript' as a way of describing the official story. It is the open interaction between dominant and subordinate, action that is openly avowed to the other party in the power relationship (Scott, 1990: 2). My interpretation of the public transcript was one of efficiency savings: publicly declaring and acknowledging that these savings were in the interest of patients and would lead to better care. In a position of dominance, this meeting could be construed as openly supporting the public transcript. For the subordinate, the pretence of deference and cooperation can also be seen as a form of open support. A function of the public transcript is to create the appearance of unanimity among hierarchal groups in order to foster a public image of cohesion and shared belief: 'Disagreements, informal discussions and off guard commentary are kept to

a minimum and, if possible, sequestered out of sight' (Scott, 1990: 55). Faced with colleagues who did not know the physiotherapy service, I wanted to avoid any impression of discord between Jack and myself. To present an image of unanimity was to present a strong team – a strong team being reflective of strong management and leadership.

> The importance of avoiding any public display of insubordination is not simply derived from a strategy of divide and rule; open insubordination represents a dramatic contradiction of the smooth surface of euphemized power.
>
> (Scott, 1990: 56)

I viewed Jack and Jim's lack of participation and ongoing silence during the meeting as an open refusal to comply with this show of unanimity among members of my service. Not only was this a breach of meeting etiquette, but from my point of view it also called into question my ability to manage and lead.

> A single act of successful public insubordination, however, pierces the smooth surface of apparent consent, which itself is a visible reminder of underlying power relations.
>
> (ibid: 205)

In retrospect, this is not just a visible reminder of the underlying power relations; it also reminds me of the interdependence of our relationship as

we both try to hold onto our sense of identity with one another. This situation was not about how much power I had over Jack or Jim as their manager, but more about how the shift in power relations enabled and constrained us in ways that we perceived as threats to our identities, evoking responses of resistance. My thoughts now deviate from traditional management discourse whereby resistance is located within the individual and seen as a defence mechanism. Spiers believes that the response of social defence – resistance – is invoked as a way of alleviating stress. In this example, my view is that resistance is co-created though organisational members' ongoing participation in interaction. The response, invoked through this communicative interaction, enables and constrains our relationship with one another – perhaps as a way of holding onto our identities when we believe them to be under threat. This way of seeing resistance as rooted in the process of local interaction challenges the notion that it is a personal phenomenon that can be located with one individual.

My experience of explicit resistance

In my view, the public transcript in this narrative encompasses a number of strategic poses that centre on efficiency savings within the new organisation. The transcript uses specific language such as 'quality and service improvement', 'transforming care of patients' and 'integrated care'. At the time, I felt we all had to defend these statements in the face of the public. The hidden transcript I thus interpret as thoughts and feelings that

were being played out among subordinate group members; and I included myself in this group, as a middle manager. What I was experiencing was this need to defend the 'public transcript' but at the same to express my own hidden transcript through my thoughts and feelings – in a way, I was resisting the strategic position in defence of my own identity. However, I was anxious to conceal these thoughts; and according to Scott, the very act of concealing this (for fear of exposure) suggests that I was stronger in my defence of the public transcript; in Scott's words, this 'contributes to a sanitized transcript' (Scott, 1990: 87). My stance was hardly surprising, in the context of potential job losses. Scott also draws attention to the public transcript being ritualistic and stereotypical in order to affirm its legitimacy:

> By definition the hidden transcript represents discourse, gesture, speech, practices that are ordinarily excluded from the public transcript of subordination by these exercises of power. The practice of domination then creates the hidden transcript. If the practice of domination is particularly strong it is likely to produce a hidden transcript of corresponding richness.
>
> (Scott, 1990: 27)

I now consider that in my actions as a middle manager, I was vehemently defending the strategic position; indeed, this is what we were all doing in the meeting, as we discussed 'transforming patient care' when in reality we were looking to save money. In my own mind, I was concerned that we

were prioritising the financial savings over patient care. My reactions to Jack and Jim's behaviour during and after that meeting were to respond to them as if they had their own hidden transcripts. This constrained my actions during the meeting, because I did not want to publicly question their act of silence; I felt further constrained by the fact there was a hidden agenda of efficiency savings, which ultimately would affect staff jobs.

Jim and Jack's outburst at our subsequent meeting, gave way to a barrage of feelings that had otherwise been concealed or repressed. In asking Jack and Jim to ignore their past work, in trying to promote the public transcript, I was constraining them by not allowing them to continue to manage their own service. At the same time, our interaction was enabling them to feel that they could question the public transcript, and in doing so to openly declare their true feelings. Scott's articulation of what he refers to as 'breaking the silence' identifies a particular political moment when the first public declaration of the hidden transcript is made. What is important is to understand the impact on those declaring, as well as on the audience (Scott, 1990: 206).

> The moment when dissent of the hidden transcript crosses the threshold to open resistance, this is always a politically charged occasion. The sense of personal release, satisfaction, pride and elation despite the actual risk often run – is an unmistakeable part of how this first open declaration is experienced.

(ibid: 208)

This enabling and at the same time constraining relationship can also be occurring within the individual. I understand that the constant suppression of true feelings required by etiquette can build tension through constant vigilance and self-censorship. This eventually reaches a point in our ongoing interactions when we feel that we must finally say what we think. In this instance, it's clear that Jim had become defensive. Scott's view of looking at public and hidden transcripts is on a par with traditional management discourses, which relates back to this concept of shared ownership or 'buy-in' as being part of the public transcript.

In management discourse, resistance to organisational change processes is located in the individual. As mentioned earlier, in a management context the middle manager's role and responsibilities are often viewed as instruments of implementation within organisation that can manage, control and influence processes through good communication and effective leadership skills.

Complex responsive processes as an alternative way of thinking about resistance

In thinking about the role as a middle manager in my organisation, from a traditional discourse perspective, leadership and management are considered personal phenomena; it is implied that I can objectively stand outside these

processes to observe behaviour – enabling me to categorise functions, roles and responsibilities, with a view to implementing corrective action. From a complex responsive processes way of thinking, leadership and management are rooted in the social act – dependent on our relationships with one another. In the examples I have provided, my participation must be considered as part of the ongoing process of how we affect one another in our day-to-day local interactions. This is crucial to understanding and making sense of what we do in organisations, because we co-create action, in the sense of thinking and doing, in our relating to one another. However, an organisation's view of the pre-defined role of manager fails to reflect my experience of my relationship with the physiotherapists. I made the point in Project 1 that when I became a manager I was expected to use systems thinking to manage effectively. I still felt that I could potentially influence, redesign and improve the service if I viewed the organisation as a system.

Through change management processes, I expected to be able to encourage others to share this sense of 'ownership' of the organisational change; but this was not happening. My experiences were resulting from how the physiotherapists and I were interpreting policy into practice. From a complex responsive processes perspective, this relates to the way we were all particularising generalisations. Particularisation gave rise to patterns of resistance in myself, Jack and Jim. Expressing a vision and getting 'buy-in' was not the answer. What I have come to understand is that resistance, like

conflict, is a necessary part of power relationships, and that seeking to overcome it may stifle the opportunity to open up possibilities for change. How we as managers respond to one another can be unexpected; and even though I understood myself to be in a position of control, in reality this does not happen. From a systems perspective, I would describe this process as interactions linking objective to outcome where relationships had no place. Stacey proposes an alternative perspective, whereby leaders and managers cannot be divorced from their relationship with others:

> In responsive process thinking, the interaction between persons is understood to produce further interaction between them. In responsive process thinking, people are thought of not as parts producing a system but as interdependent persons producing patterns of relationship, which produce them as selves at the same time.
>
> (Stacey, 2010: 325)

In complex responsive processes thinking, there is no notion of hierarchical levels of human action (ibid: 325) and no separation between individual and organisation. The theory seeks to understand how we function in hierarchies – which are, after all, patterns of relationships between people. Individuals are the singular and groups are the plural of interdependent people. This is an important point, because clearly my previous assumptions about this idea of role were based on a manager–subordinate relationship. I now recognise

that it is more helpful to consider the relationship and our ongoing interactions, rather than to think about managerialism in a way that detaches managers from the processes of responding. Stacey makes the point that 'relationships emerge from relationships' (ibid: 325), rather than intentionally created plans designed by individuals. This has more to do with our interdependence.

In this narrative, there is a strategic directive – a plan of how we take forward organisational intentions; but what is clear is that the processes of responding to one another on a day-to-day basis do not follow this set plan. What happens in the relationship takes over the way I think and respond. This way of thinking also calls for a different approach to methodology – one that centres on how we acquire knowledge through our day-to-day experiences and how to capture these patterns of interaction.

Can middle managers remain objectively detached?

Midway through the year, the strategic direction had been confirmed as one of full integration between the hospital and community services. I was already immersed in integration with the department of Nutrition & Dietetics, which Charlie would soon be handing over to me. However, the issue about what to do regarding physiotherapy services across the two boroughs remained unresolved. Ivana spoke about the executive decision on the physiotherapy service. She pointed out that there were two managers already in post, Charlie and Jack; and that this provided an opportunity to

deliver efficiency savings by having just one manager. My management of the physiotherapy service was always meant to be temporary, until an integrated structure could be defined. Since that structure had now been defined, I would be managing only the integrated service. I knew that this would happen, so I should not have been surprised; but I was still a little upset that my interim management of physiotherapy was to be cut short. Ivana told me that once the consultation papers were sent out, I was to inform Jack that his job would be at risk. At the same time, Charlie would also be informed that her post was at risk under the proposed new structure.

Naturally, I was extremely anxious. I knew Jack was not expecting this. Although we had many discussions on the way the organisation was changing, and on the imminent management restructuring, I had always anticipated that he and Charlie would work together. I was concerned for Jack and wondered how to break the bad news. When the moment came, I called him to explain the situation. There was a long silence; I stupidly asked if he was all right. (What was I thinking? Of course he would not be alright, given that I had just informed him that his job was at risk!) He asked why this was happening; I explained that this was the strategic direction, and that the executive team were taking this opportunity to make savings. I added that there would be a consultation, and there was a likelihood that he would have to reapply for his job.

I was trying to remain detached and objective by saying that he would be treated fairly through a human resource process, as if somehow this would allow me be to remain emotionless and be able to get through this whole situation. I was hoping that if I took this approach I would escape my discomfort at feeling responsible for Jack's fate. Jack was probably calmer than me in this conversation; rather graciously (considering that our working relationship had never been easy), he acknowledged the rationale for cost savings – but this did not feel any more palatable to me. I tried to reassure him that the human resource process would ensure fair and equitable treatment; but at the same time I was remembering that only a week ago, Ivana and I had been discussing the most suitable candidates to replace Jack; Ivana would be chairing the interview panel.

Over the next few months, Jack became more withdrawn at work; he was clearly disengaging from the team and excluding himself from the other physiotherapists – even Jim. I could still communicate with Jack, but only in the privacy of my office. He no longer attended any team meetings, and I did not force the issue. When he was in the office, he disrupted the junior managers from their work; they also found it difficult to share the same office, knowing what he was facing. In the end, I suggested he use one of my other offices, so that he had some privacy to update his CV in readiness to reapply for his job.

I also met up with Charlie, who remained optimistic about her position but was seriously considering other life changes if her application was not successful. As it turned out, she got the job; while the junior managers and I were happy for her, at the same time we felt for Jack, knowing that he would now face an uncertain future. I questioned whether we could have done things differently. But the reality was that despite the managerial systems and processes we had in place to support staff through organisational change and ensure equity and fairness, the act of relating to one another – and how we were transformed by these acts of relating – impacted more on decision-making than the notion of remaining objectively detached.

Can one stand outside the conversation?

In day-to-day organisational life, it is inevitable that middle managers are expected to have difficult conversations. There are even 'gold standard' guidelines on breaking bad news (NICE, 2004) and the guidance recommended training for healthcare professionals to ensure consistency in their approaches to communication.

During my telephone conversation with Jack, I anticipated being able to manage and contain his emotions by going through this seemingly objective process – detaching myself from the fallout of his emotions in order to deal more effectively with his anxiety. If I relate this back to my thinking at the time, I still believed that a manager's skills and abilities

would enable them to be effective in their role. What was clear from this conversation (or lack of conversation) with Jack was that nothing could be prescribed to enable him to respond in a certain way, nor could I influence the conversation when I felt constrained by his silence. Realising this raised my own levels of anxiety.

From a complex responsive processes perspective, I now understand that I cannot prescribe patterns of communication. In my second project, I referred to Mead's (1934) view on human communication as conversation where meaning arises in the ongoing process of gesture and response, which taken together form a social act. Meaning therefore cannot be prescribed in one-way clarification, as in the traditional sender–receiver model. Instead, there is an 'ongoing responsive process', which Mead referred to as 'conversation of gesture'. Stacey (2010: 338) asserts that 'there is no objective position external to the conversation from which someone can control, shape, influence or condition the conversational process of turn taking and turn making'.

Elias (1987) provides a view on involvement and detachment in relating to one another. To be involved evokes more emotion and unconscious participation, whereas to be detached is to be less emotional and more conscious in our participation. These cannot be considered separately from one another: in our processes of relating to one another,

there is a paradoxical relationship of involved detachment and detached involvement.

During the course of my conversation with Jack, our interaction both enabled and constrained us in involved and detached ways. When I felt constrained by Jack's silence, this heightened my emotions, leading me to react more unconsciously. At the same time, Jack's response was not what I had anticipated: he was much more guarded. The conversation seemed more one-sided, with me reiterating the justifications for putting his job at risk. Jack's silence led to a stilted conversation. The more I tried to control it, the more difficult it became to elicit a response from Jack.

It seems that prescribing a way of communicating in order to influence or control a conversation can limit any potential for exploration by limiting the responses; yet here I was, with my preconceived notions of what my role was and how I would manage this difficult situation. In the end, I emerged from that conversation with an overwhelming sense of not handling the situation well. What I note further is that the more I tried to take control the more defiant Jack became, which led to an eventual breakdown in our ability to relate to one another.

Conclusion

In this project, I was interested in how middle managers in the NHS respond to resistance to organisational change in defending the strategic position. I wanted to explore how middle managers viewed themselves within the

organisation, and what effect this had on power relationships with subordinates. As part of this, I wanted to further explore the way we think about resistance – comparing the perspectives of traditional discourse to those of complex responsive processes. First, I discuss this notion of role and function of middle managers, particularly within managerialism, where they are viewed as implementers of change but are also the most likely group to be restructured.

My thinking at the time was very much that management was a scientific phenomenon; that I could objectively stand outside the process in order to influence and control it. What I now understand is that patterns of behaviour arise from many local interactions. This notion of role is clearly linked to my own identity within the organisation as I struggle with an existing identity and try to understand how this changes as we move to integrate services. In a social context, it becomes clear from my local interaction with subordinates that we are interdependent and that in terms of the group, differences arise from many local interactions.

Power is seen as a structural characteristic of individuals relating (Elias,1991) and its significance within a traditional discourse is again located within the individual as a source of influence and control. By contrast, in considering it as something that arises from relating in the social process of 'game', we can see that it is dynamic and both enables and constrains relationships. If we consider power relationships in relation to

identity, what is of interest in the broader context of organisational life is how we as a group of middle managers further subdivide ourselves through this process of inclusion/exclusion, in which we are all co-creating through these power relationships. In organisations, we seldom acknowledge these subgroupings that arise from polarised views. And this lack of understanding of these organising processes can interfere with the emergence of new possibilities for change, through the amplification of defensive behaviour in the form of resistance.

This is not to imply that resistance should be managed or controlled; rather, I would suggest resistance is a necessary part of the way we respond to change. From a traditional management perspective, the 'top-down' approach to changing organisational culture and identity by instilling new beliefs, values and working relationships does not ensure that staff will not resist; indeed, these efforts can often be seen as threats to identity. We tend to view resistance as a negative behaviour – a personal phenomenon that must be managed and contained. From a complex responsive processes way of thinking, however, resistance can be understood as a social process, and arises from our acts of relating. Rather than considering it as negative behaviour that blocks organisational change, it can be seen as a necessary part of local interaction where new thinking can emerge.

In conclusion, I believe that as middle managers we cannot stand outside process. We are participants in interaction; thus, the way we relate

to one another inevitably affects the processes of how we respond to one another. I propose that we rethink our perception of the role of middle managers as change agents; in doing so, understanding these organising processes such as resistance may be a better way of looking at new possibilities to emerge from change.

Project 4

Understanding integrated care and the experience of prejudice

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Introduction

The focus of this narrative is on a newly merged NHS organisation, which now encompasses both the hospital and community staff. In the past, these two groups worked very differently. The hospital group had a strong medical leadership; the community group had a strong nurse and allied health professional leadership – such as physiotherapists, dietitians, occupational therapists. My role was to try to integrate the teams towards a common ideal that would enable patients to receive integrated care. This project explores my attempts to get the hospital and community teams involved in cardiothoracic medicine to work towards this common ideal. I needed to encourage the teams to start engaging with one another; to gain cooperation and reduce any opposition or resistance, I planned to start this process of engagement with the doctors and a wider group, believing that securing consensus among the medical staff would enable us to begin to work together, despite our differences.

Communicating this idealised view at meetings with the doctors and stakeholders was not straightforward: each group had strong identities

relating to their history and traditions in their previous organisations, and saw working with the other as a potential threat to this. Both sides had a particular view of one another based on their prejudices. My attempts as a leader to communicate a vision of integrated care at the stakeholders meeting were not successful in achieving the outcome of consensus. Getting 'buy-in' from staff by aligning values and setting a common goal is seen as important in reducing any conflict or resistance to change in change management processes. What I had not anticipated was the subsequent conflict that arose as we all argued about what 'integrated care' meant. In the course of the conflict, people's prejudices about one another were revealed by their assumptions and stereotypical views they had of one another. My leadership training and managerial experience had not enabled me to influence or change the course of the conversations. I tried to remain objective, but on reflection found that I too had my own prejudices about staff groups, which were influencing the ways I was thinking and acting.

This has led me to question how we come to understand prejudice when trying to operationalise an abstract ideal of integrated care. I firstly explore how interpreting idealisations are affected by membership of different groups with very different histories and traditions, and how this difference forms the basis of prejudice. I then go onto examine the ways in which prejudice is experienced in organisations in our daily interactions with one another. I will be reflecting on critical incidents that led up to a

stakeholders meeting. In my exploration of interpreting integrated care, I will be discussing how traditional organisational change management techniques are not helpful in thinking about how prejudice affects ongoing relationships and interactions. Finally, I present Hans-Georg Gadamer's way of thinking about prejudice, which helps us to understand what takes place in our process of understanding, and argue that from a Gadamerian perspective of understanding we can never fully escape from all our prejudices in organisations (although that does not mean we cannot revise them).

Our prejudices are rooted in our historicity and links with our ways of doing things, our traditions. We cannot erase or discard our background, our history, by implementing change management processes designed to objectify the process of interaction, which seeks to disassociate managers from the process. It is only through conversation that we can experience the other; and this requires us to think of the concept of prejudice not only as a way or excluding or invalidating, but paradoxically, at the same time, as a way of opening up possibility to understanding.

Remembering the good old days

I sat in silence as Ivana, the newly appointed director of operations, confidently presented her vision for the future and her strategy for the division. It was the first one-to-one meeting I had managed to have with her since my appointment a month ago. I was wondering whether I was suited

to my new job: having been a community middle manager for 11 years, I was now expected to lead on integrating clinical services across hospital and community and to develop ways of working that would join up patient care. Now that the hospital and community had merged, I assumed there would be no organisational boundaries preventing us from working towards this goal.

‘So, Fiona, what are we going to do to get the services – and in particular, the doctors –on board with integrated care?’ Ivana asked. I pondered the question. Allwyn Medical was now a newly merged organisation, made up of what had been the Allwyn Hospital NHS Trust and NHS community health services from the counties of Wyth and Durren. Although Wyth and Durren had formed an alliance the previous year, staff were not yet familiar with each other – a problem compounded by joining with the hospital, as the organisation had tripled in size. Hospital staff gossiped that there had been a ‘take-over’ by community services; community staff talked about the hospital dominating the community and swallowing up all the resources. Other managers were aware that two-thirds of the new organisation’s senior management structure were community managers.

‘My heart will always be in the community,’ Ivana mused – echoing my own sentiments, which I suddenly realised neither of us could declare publicly. We both complained about the doctors, discussing the difficulties

we were having in working with them. We felt that their previous managers had spoiled them and pandered to their whims. They were unhappy at the large proportion of community managers who now seemed to occupy the headquarters, and were vocal in what they saw as a 'take-over' of their hospital that would lead to an erosion of their services. Of course, this was not true; Ivana had advised me to take an autocratic approach, indicating that they had no choice in the matter. 'Failure is not an option,' she asserted – easier for Ivana to say, since it would be me doing the telling.

I had to try to bring the hospital and community groups together and look at how we could work towards integrated care. In doing so, I was hoping that we could perhaps iron out any differences and reduce any negative feelings each group might have towards the other. I expected this meeting to be difficult, being the first time that staff from hospital and community would be in the same room together. I told Ivana that I would meet with the cardiothoracic physicians first; I could then brief them on the meeting, as well as try to get an idea of their characters and whether they were likely to agree to the idea of integrated care. I anticipated some resistance, given that my idea of integrated care would change the ways of working and mean that doctors were no longer the overall decision makers in patient care. Ivana warned me that they were among the most difficult doctors to manage. I worried about how I would deal with this situation.

Meeting Dr Saeed and Dr Wilson as their new manager

I met Dr Saeed and Dr Wilson together, both of whom were very knowledgeable about their areas of cardiothoracic medicine. I was struck by how insightful Dr Saeed was in understanding the needs of the local population and the wider strategic context of integrated care. I put this down to his role as an adviser to the Department of Health. Both conversations seem to take a similar line: each emphasised that we should not change anything in the hospital, because hospital medicine already had a strong governance structure and a good history of providing evidence-based care. They were insistent that we should not try to discourage GPs from referring patients to hospital. Supportive of the concept of integrated care, they saw it as an opportunity to spread good practice to the community and develop medically led pathways (I found myself having this pattern of conversation with all the doctors). They both expressed concern that community teams had been operating without strong clinical governance and that even though the teams had built relationships with GPs, the GPs had insufficient expertise around cardiothoracic medicine to make complex clinical decisions. They saw integrated care as an opportunity to improve clinical governance, implying that medically led pathways were safer for patients and that GPs would be more assured of appropriate care for their patients.

Their views of community services were that they did not have the capability to take on any specialist work. I was shocked by the arrogance of

these assumptions: the community had developed some very senior roles among other healthcare professionals, such as nurses and allied health professionals, to make complex clinical decisions. Rather than acknowledging this in our conversation, the doctors seemed to view integrated care as a chance to extend their power and influence by having medically led models in the community. They hoped I would push for more consultant time so that they could develop a fully integrated model with cardiothoracic physicians supporting the GPs in the community.

I was surprised by the doctors' assumptions and the generalisations they made about community staff. They had formed their opinions without having met any of the Durren team. I was annoyed at their assertions that Durren was not practising in line with current evidence, based merely on the fact that they were not recording their data in the same way as the hospital teams.

Not wishing to alienate the doctors because I needed their cooperation, I invited Dr Wilson to present at the stakeholder engagement event. However, I was itching to tell them how old-fashioned and blinkered their views were. To my mind, they were spouting nonsense. Obviously, I was particularly offended by their dismissive comments about Durren. I tried to phrase my displeasure in a diplomatic way, saying that I was certain that the community teams were practising within the correct guidelines and that the GPs seemed very happy with the service they were providing. To a

certain extent, I tolerated their views so that they would not suspect how I really felt about them. I was worried that I might not gain their cooperation to attend and participate in the stakeholder meeting. I felt at the time that this was manipulative or coercive of me, but persuaded myself that the end justified the means and that I needed their participation.

Nevertheless, I came out of that meeting and felt that nothing had changed: doctors' attitudes were still the same as they always had been regarding community working. Inwardly, I was seething: this behaviour only reinforced my own feelings towards doctors – that they were arrogant and caught up with their own self-importance. We were an organisation in name alone, because the doctors seemed to have such differing views from myself and other managers. In tolerating this awareness of the doctors' views, which I thought were completely biased towards the hospital, I also felt guilty. I should have defended my community colleagues more fervently, and was worried that my silence would be taken as a tacit assent to the superiority of hospital working.

The stakeholders meeting

I had invited a number of people to the stakeholder's event, although it was originally intended for Allwyn Medical staff only: it soon became apparent that other people, external to the organisation, should also attend, so that we could get wider views on integrated care. I decided it was important to invite the GPs and commissioners – we might have different ideas about

how to implement integrated care, but should at least be in agreement about the basic principles, so strong facilitation and a clear agenda would keep us focused on the main issues. Nevertheless, I also took a risk by inviting a patient along, so that their views could also be heard. I considered this carefully, wondering if the teams might feel unable to express their views freely in front of a member of the public and whether the patient might feel inhibited by the numbers of professionals attending. There was also an ulterior motive: by having a patient attend, staff might be more mindful of keeping the conversations professional in the event of any conflict. Airing one's dirty linen among NHS staff was one thing; but to air it in front of a patient would be overstepping patient/professional boundaries. We certainly did not need to be exposing our deficiencies to other stakeholders outside the organisation, least of all to patients.

The presentation started well, with a summary of work currently provided by both hospital and community teams. I could see that the whole group agreed with what Dr Wilson was saying around the gaps in service provision. I was relieved that the timing was going to plan, and expecting Dr Wilson to wrap up her presentation. However, despite giving her the signal to start finishing, she continued for another 20 minutes in what I could only describe as a critical monologue of the community teams' failures to provide the right care. The attack was subtle, but comments like 'This is questionable' or 'I have no idea why it's done this way' provoked

outrage among the community staff and GPs. I cut Dr Wilson off from speaking any further, by telling her we were out of time and trying to move on; but it was too late – the damage had been done. I knew the GPs and community staff were keen to retaliate, but at this stage were still following the agenda. I handed over to the facilitator, but started by explaining what we were to all do in the next session, suggesting we start by mapping the services in the community.

This was the opening that the participants needed in which to respond to Dr Wilson's barbed remarks. I could almost feel my hands cover my eyes as I cringed in anticipation of what was to happen next. A major argument broke out among the GPs, with accusations from the Wyth GP that Durren had never properly invested in their services, so it was hardly surprising that their rates of cardiothoracic illness were high. The Durren GPs were naturally defensive, but retaliated by implying that Wyth had been spoilt by the luxury of larger budgets; of course they were able to afford more costly practices. Durren was a challenging district, with high levels of deprivation and a history of social unrest, public rioting, and a health and social care system that had been heavily criticised in the past for its failures in two high-profile child protection cases. Those of us who had lived and worked in Durren always felt that this history tainted people's opinion of us, and we were sensitive to any negativity directed toward Durren. Inwardly, I found myself siding with the Durren GPs.

The GPs were at loggerheads with one another. Their respective commissioners then entered into the argument, which now progressed into the way services were commissioned in both districts. Meanwhile, the hospital team started to voice opinions that differed from those of their community colleagues on which patients should be included in the pathway. This led to a full-on attack by Dr Saeed and Dr Wilson on community practices, which they saw as not being properly assessed with regard to the quality of care – particularly criticising the care provided by the Durren team. The hospital staff made a point of emphasising their commitment to recording quality outcomes, and that they had a history of presenting good-quality data. There seemed to be a power struggle going on at this meeting. The Wyth GPs were trying to gain the upper hand over the Durren GPs by criticising lack of appropriate investment. The hospital staff and doctors trying to gain the upper hand over the community staff by criticising the way they collected data.

I was livid at the cardiothoracic consultants and the Wyth GP, who all seemed to be pointing the finger at Durren instead of cooperating in exploring what integrated care would look like now that we were one organisation.

Despite my anger, the overwhelming need to show a united front was important to me. I had to show that as a new organisation we were all signed up to integrated care, so I tried to reframe this concept by attempting

to steer the group into thinking about how we could work in a joined-up way that would benefit patients. My efforts failed: we ended up with a slanging match between the hospital and community regarding who provided the best care, who recorded the best data, who was better at investing in services. Although I felt it was important to be defending and upholding hospital working, I was still thinking as a community manager. I still hoped at this point that we could get back on track, if only I could somehow steer the conversation away from everyone blaming each other.

I needed a way to deflect. I was silently working out my next move. The community teams flatly refuted the hospital accusation and retaliated by saying that current evidence that suggested costly hospital doctors were not necessary to support patients in the community, which of course had the agreement of the GPs. This infuriated Dr Saeed, who interjected by insisting that the work he was doing showed the benefits of having cardiothoracic physicians looking after patients in a community pathway. I saw this as his attempt to stamp his authority by giving credibility to his argument, in proclaiming his expertise. I felt embarrassed for my community colleagues, and was appalled that the consultant physicians could display such open hostility towards community staff – casting doubt on how community services were operating.

Throughout these heated exchanges, I had become aware that the patient, whose breathing was increasingly wheezy, might want the

opportunity to say something; he was looking at me expectantly. I called order and invited him to speak. There was immediate silence. He thanked me for the opportunity to speak, apologised for his wheezy speech and said that he really appreciated being invited to the meeting. I was concerned that he was having some difficulty talking; but he managed to say that he was a resident in Durren and had only ever had experience of good care by the cardiothoracic teams who worked in Durren. He also praised the services at Allwyn Hospital.

The patient did not speak for long, but made a simple statement: 'All I want is to be able to have my care at home, when I need it and only in hospital when I need to be'. A moment of silence descended, during which it seemed that we all took a moment to reflect and that this simple statement had brought us all back to reality. I was ashamed of my staff and their behaviour. The patient had had to sit and listen to all the stakeholders arguing like children about who was the best, trying to undermine one another in public. It took a few words from the only person in the room who mattered, to make us remember why we were all there.

I hoped the doctors were feeling ashamed of their behaviour. It seemed we were all struggling to understand how we were going to work together in this new organisation. We were clinging to all the things that made us who we were, and trying hard to resist the things we could become because this threatened who we were. In the end, we had finally reached

some consensus that we would need more thinking time and a chance to come together again to discuss. We all agreed to go away and consider what our next steps would be – with a flurry of suggestions from people who, just a few minutes ago, had been at loggerheads with one another.

I was disappointed that the arguments between hospital and community staff had taken up most of the time. It seemed to me that everyone thought integrated care was a good idea, but no one was prepared to make any changes to support it in practice. Nevertheless, on reflection, I feel that something did shift – either in response to the patient's narrative, or because we finally came to realise that we needed to work together and take another step forward to try to work out our differences for the sake of the patients. The meeting ended with an agreement for Allwyn Medical staff to look at improving their own internal processes and then meet with the respective district GPs in the New Year.

Implementing integrated care

Understanding integrated care

From a DH perspective, 'integrated care' is seen as a 'transformation attribute' (DH, 2009). From my organisation's perspective, we would take the transformation agenda forward by redesigning clinical pathways of care; and cardiothoracic medicine was one of the focal areas I was expected to transform. My intention was that Allwyn Medical would provide local

joined-up care with GPs, which could be achieved though the implementation of new service approaches such as new patient pathways. This could involve integrated team development (ibid: 14). The national policy context for provider organisations such as Allwyn Medical was to ‘align high quality care to organisational vision and strategy’ (ibid: 6). It is important to distinguish the difference between the term ‘integrated care’ and ‘integration’. According to the Nuffield Trust, there are 175 definitions for ‘integrated care’, and such diversity reflects the imprecision in the way we may interpret what this term means (Shaw et al, 2011). According to Lloyd and Wait, it is an ‘organising principle’ for care delivery (Lloyd & Wait, 2005: 7), with the aim of achieving improved patient care through the better coordination of services. This idealistic view underpins what we understand as an integrated care organisation (ICO).

Integrated care is an idealisation that is in keeping with the ideology of health care. In my interactions with both hospital and community staff, I noticed how we were attempting to articulate our own interpretations of this idealised view. Stacey (2010) describes this as ‘particularisation’ – an explorative process of negotiating meaning of integrated care and operationalising this in a local context. This process in general can be conflictual. He describes idealisations as an imagined whole or unity of experience (Stacey, 2010: 192). These population-wide patterns of behaviour are paradoxical, in that the idealisation is forming our way of

thinking while at the same time we are reflecting and particularising through our reinterpretations of our thoughts to form generalisations and idealisations. The way that we particularise is contingent on particular situations at particular times. However, reflection and meaning making are all activities of abstracting, which are articulations of both local and global patterns of interaction (Stacey, 2011: 414). In abstracting, we are drawing away from a particular experience. Through our local interactions, meanings from abstractions emerge.

At the stakeholders meeting, we were all immersing and abstracting as we participated in the experience of attempting to apply this imagined whole of 'integrated care' to this particular contingent situation. This abstract idealisation I was experiencing in our interactions was so far removed from the actual situation that I felt alienated from my colleagues in my efforts to uphold this ideal without taking into consideration how they might feel about the newly formed organisation. At the same time, I felt I was alienating them further because this abstract idealisation was so fragmented from their own ideals and ways of working that there was no consensus on how to move forward together. What I observed was that everyone – GPs, community staff, consultant physicians, and myself – was particularising upon their own contingent situation. It was hardly surprising that the groups were prejudiced about the other groups if they were interpreting integrated care according to their own ways of working.

Planned meeting to bring people together

I had an idealised concept of integrated care, which I was expected to operationalise. I somehow had to sell this idea to the cardiothoracic physicians and the cardiothoracic teams, in the hope that we would be united in our understanding and able to work together on its implementation. To do this, I felt I must appeal to the team's sense of working together for the greater good of the patient. I was aware that in transforming the services, I would be expected to make efficiency savings. However, I was convinced that if I could demonstrate to Ivana that the teams and consultant physicians could work together, then we would be assured of productivity gains and a more efficient, cost-effective way of working. To get to this point, I needed the teams and the doctors to agree to the concept of integrated care and cooperate with one another.

At this point, I refer to the views of Edgar Schein (2004) to illustrate how I was thinking from an organisational management perspective in my efforts to manage and influence conversations around integrated care. Schein's perspectives on how leaders can influence organisational culture typify management discourse that situates actions of influence and change with individual managers and leaders. In *Organizational Culture and Leadership*, Schein discusses how to transform the idea of culture into a practical tool that managers can use to understand the dynamics of organisations. Although at the time I did not set out with the specific

intention of applying Schein's principles of culture change to achieving the strategic goal of integrating care, I certainly recognised some of my actions among those that he cites as critical success factors for leaders of organisational change.

I felt that the processes of communication were important in developing some form of unanimity with the doctors and the cardiothoracic teams across the hospital and community.

> To function as a group, the individuals who come together must establish a system of communication and a language that permits interpretation of what is going on.
>
> (Schein, 2004: 111)

Schein refers to the fact that people cannot tolerate too much 'uncertainty or stimulus overload'. My interpretation of his theory is that if people can somehow share collective meaning that can organise perception and thought, then they can focus on what is important and discard anything that is not. In doing so, anxiety levels are reduced, creating an environment for coordinated action – that is, alignment with the strategic direction. According to Schein, when new groups come together, in order to form, they need to learn each other's meanings and understand each other's language; the leader must be able to identify each group's categorisation of meanings in the group's actions, gestures and speech (ibid: 115–116). This sense of commonality is strengthened by what Schein attributes to an

investment in special meanings and assumptions of what the words really mean; this, he believes, is what supports and maintains group culture. He is clear that in bringing different assumptions of meaning into the open, they can be addressed in a consensual way if leaders acknowledge them, accept them and reframe interpretations in a way that will obtain consensus. Crucially, a leader must act as both participant and observer. Schein acknowledges the importance of leaders participating in the interaction, but suggests that they must also be able to objectively observe in order to assess situations and intervene in the interaction.

At the time, I was thinking that I wanted to get the doctors to support the idea of integrated care so that we could start to get the teams to work together. This did not happen in the conversations that I had with Dr Saeed and Dr Wilson. They were vocal in what they considered were the differences in the way care was provided in the hospital, and condemning of community services – in particular, Durren. They also made clear that they did not feel that any hospital services should change. Similarly, at the stakeholders meeting, my attempts to control the meeting by having an agenda did not achieve the outcome I had intended.

Prejudice revealed when the groups meet

Schein argues that leaders are in a strong position to control and influence people. He refers to individuals as though they can act independently and objectively to improve the system from 'outside'. I think his arguments hold

great appeal regarding the level of influence an individual can have by using tools for self-improvement, particularly for leaders and managers undergoing rapid organisational change. However, he does not focus on the importance of how the experience of the individual and group affect one another. If things do not go right first time, he advocates repetition of action until there is consensus.

Schein pays little attention to the experiences of people in how they affect or are affected by their day-to-day encounters, other than to make the point about the importance of leaders and managers in influencing how people come together. Yet in my narrative, I was affected by my own experiences. This in turn prejudiced the way I was thinking and responding to others, in particular the doctors, as well as my thoughts around how integrated care should be provided and my feeling that this should be community focused and led. At the time, I did not want to acknowledge this as prejudice; so I justified this by assuming that it was the right thing to do for patients. Schein relates culture change to developing shared values as a way of bringing groups together:

> If espoused beliefs and values are reasonably congruent with underlying assumptions, then the articulation of those values into a philosophy of operating can be helpful in bringing the group together, servicing as a source of identity and core mission.

(Schein, 2004: 30)

He refers to the fact that culture change can, in part, be achieved by aligning strategies, goals and philosophy. This is where I do not now agree with Schein: my experience of getting people into a room together and articulating the idealisations of integrated care did not bring the group together. However, it did expose prejudice in the ways that we were thinking and in our interactions with one another, by challenging our previous organisations' traditions and historical ways of doing things, thereby threatening our identities of hospital and community working. For example, the doctors clearly wanted a medical-led model of care, being accustomed to this way of working in a hospital environment. The community teams had always worked in a multidisciplinary way and not being accountable to doctors.

At the stakeholders meeting, a power struggle took place between hospital staff – in particular, the doctors – and community staff. I personally viewed this as a threat to my own community identity and my community ways of doing things for the good of the patient. If we now consider this pattern of behaviour from an organisational perspective, then change management processes would often involve some ideal planned outcome that organisational members would strive to achieve. Managers are often responsible for mobilising staff towards an ideal. In doing so, they can be disconnected from the reality experienced by others, as well as from their

own reality. However, the experience of interaction cannot be separated, as in organisations we are all participating in activities of immersing and abstracting.

Prejudiced against prejudice in organisations

The group relationship and prejudice

The purpose of meeting the doctors and holding the stakeholders meeting was to try to unite the groups in a common purpose through a shared vision of integrated care for patients. In bringing the groups together, I had anticipated that we would overcome any existing bias or prejudice by getting to know one another. Allport, in his work on understanding prejudice (1954), was among the first to suggest that bringing groups together might provide a basis for improved intergroup relations. Sherif (1966) showed how cooperative contact could be established after the imposition of a categorical distinction that reduced in-group favouritism. Other authors have also researched extensively the notion of bringing groups together as a way of creating more harmonious intergroup relations (Brewer & Miller, 1984; Hewstone & Brown, 1986; Pettigrew, 1997; Wright et al, 1997). In addition, Gaertner and Dovidio (2000) devised their common in-group identity model to explain why cooperation and contact could be successful in reducing in-group bias and prejudice; when psychological boundaries between different groups are broken down, new

overarching groups can be formed (Crisp & Beck, 2005). However, contrary evidence can be found in studies on organisational mergers. Mergers can cause previously distinct groups to engage in heightened in-group favouritism (Terry & Callan, 2001). This motivation to retain a distinct social identity may explain why groups try to hold onto their previous organisational identity (Hornsey & Hogg, 2000).

Social identity, conflict and prejudice

Many writers – including Tajfel and Turner (1979), Turner et al (1987) and Abrams and Hogg (1988) – have argued that we are not simply passive members of a social group. Some groups mean more to us than others; and when they do, we use them as a source of self-esteem. Since groups are invaluable to self-conception, people want to maintain the perception of them being positive and clearly distinguishable from other relevant comparison groups. Moreover, this 'social identity' interpretation of how groups relate to one another holds that people are more sensitive to difference in status between groups, and that they will try to sustain a positive identity for their own (Abrams, 2010). Sherif (1966) highlighted the role of conflict in relation to prejudice, proposing that groups can be in conflict if one group's loss is perceived as another group's gain: in this instance, it would seem that hostility, negative stereotypes and prejudice will inevitably follow.

Contrasting values, social categorisation, stereotyping and prejudice

Abrams (2010) describes prejudice as having a variety of bases. He asserts that values express what is important to people in their lives, such as social justice, social power, equality and respect for traditions. If values are contrasting between groups, prejudice can emerge. According to Abrams, social categorisation and stereotyping create the potential for generalisation about members of the group. This can become prescriptive rather than descriptive, and can provide socially unquestioned mechanisms for discrimination. The process of using social categories also brings about another powerful process (ibid). Schneider (2004) argues that we stereotype in order to make subjectively 'informed' judgments about others and ourselves. Abrams suggests that stereotypical expectations help to make life predictable, but are often misapplied: 'Erroneous application of stereotype may often be an innocent consequence of pragmatic social categorisation to apply a general image about a whole category to a particular member of that category' (Abrams, 2010: 20).

Prejudiced against prejudice

I do not use the term 'prejudice' in a pejorative way, but reclaim it as a particular way of understanding. The views reflected by others and myself represented either hospital or community; there was a clear divide. However, I wanted the hospital staff to accept me. This meant that I could not openly admit my allegiance to the community; but the attitude of the

doctors, in particular, continued to reaffirm my reasons for joining the community in the first place. They still felt their ways of working were superior to that of the community, and I felt they displayed their prejudices about community staff by suggesting that community practices were less safe than those of the hospital, making snide remarks about particular individuals.

While I considered their views unfair, I may not have been without blame in perpetuating their prejudices: I believed hospital staff to be archaic in their thinking, and completely oblivious to the government's broader agenda of moving care closer to home. I was keen to understand what was happening in our relationships and interactions that affected the way we behaved towards one another.

Most of the authors so far cited have researched prejudice in a specific context – focusing on it as problematic, relating it to some form of devaluing of other groups or individuals. However, I can now see that prejudice can also arise for more positive reasons – that is, from an acknowledgement of difference and affirming a sense of belonging. Because prejudice has so often been defined as problematic in organisations, we have often sought to measure, predict or even prevent it from occurring – requiring us to think in ways that would seek to reduce or eradicate it from any process of interaction. In effect, I was prejudiced against prejudice. A complex responsive processes perspective, however, may offer an

alternative way of understanding prejudice: as an ongoing response that emerges in social interaction where there is difference or diversity. It is embodied in our traditions and histories of groups we have identified with. We might consider prejudice as a thematic pattern arising in local interaction that will organise our experience of being together.

What I surmise now is that prejudice, in the context of bringing teams together, arose not only because of a sense of difference, but also where there were threats to identity emerging from power struggles between hospital doctors and community staff. Whereas I would have previously considered this as a negative consequence of organisational change, and something to be avoided at all cost, this proved impossible despite my attempts at influencing the situation. There were no overt insults traded in my meeting with the doctors, nor even at the stakeholders meeting; yet there were clearly subtle implications about the characters of the groups – for example, the Wyth GPs implying that Durren GPs were in some way inferior in their healthcare provision because they did not invest appropriately in services. Likewise, the hospital consultants implied that the community staff were less effective in their practice because they did not keep quality data.

Farad Dalal (2012), in his recent book *Thought Paralysis*, discusses the processes of discrimination, which he closely links to prejudice in relation to race and culture. He argues that processes intended to address

discrimination are in themselves discriminatory, and any attempts to promote equal opportunities are hypocritical given that it is human nature to divide and experience difference. This natural inclination means that we will always inevitably form judgments about others; discrimination can be viewed as a crucial way of legitimising our own position as individuals and within our social groups. Dalal has taken up Elias' way of thinking when he talks about the perceived less powerful being more likely to find themselves in situations where they are continually obliged to exercise tolerate (ibid.: 214). This capacity for tolerance, as Dalal explains, could be described as 'helpless compliance' (ibid:214).

Griffin (2002) believes that there is very little tolerance for difference or diversity in organisations. If that is the case, then it is not surprising that bringing hospital and community together, as one organisation would lead to intolerance. Griffin attributes this to the dominance of systems thinking, where individuals are understood as parts of the system – so that in extremes, difference can be understood as dysfunctional. In organisations, we attempt at all cost to avoid any sort of conflict, and focus on uniting the parts of the system to conform with some abstract sense of a whole, rather than of self (Griffin 2002: 202). Griffin suggests that conflict is necessary in the transformation of identity, offering two ways in which we would deal with this in organisation:

> We can seek through conflict the active recognition of difference and thus at all times recreate and possibly transform our identity.
>
> We can do the opposite and collude to actively deny difference and in doing to affirm identity with no possibility of change and no sense that identity is necessarily real.
>
> (Griffin, 2002: 198)

I think Griffin's second point is an interesting one in my consideration of how we act in relation to prejudice. As Griffin suggests, our attempts in organisations to avoid conflict can be seen as collusion to actively deny difference. In my situation, it was pretence in denying difference: I was trying to convey a sense of unanimity, even though I did not necessarily agree with it or want it. In taking a traditional management view, my attempts to bring people together failed. I anticipated that the teams would welcome working together in the new organisation and what occurred at the meeting was unexpected. However, if difference is inevitable where patterns of action will emerge in our day-to-day interaction, how else might we think about prejudice in a way that does not paralyse our thinking when we are confronted by it, because of concerns around what the word implies?

Thinking of prejudice in ways that enable understanding

Gadamerian hermeneutics

Gadamer (1975) was a leading figure in the philosophy of hermeneutics. He took issue with the way that prejudice was viewed and the negative connotations of the term. His view is that rather than closing us up, our prejudices are themselves what open us up to what is being understood, and he attempts to retrieve a positive conception of prejudice. Rather than thinking about prejudice as opinion formed without reason, we could think of it as an opinion formed in the absence of our ongoing experience together.

> All that is asked is that we remain open to the meaning of the other person. But this openness always includes our situating the other's meaning in relation to the whole of our meaning or ourselves in relations to it.
>
> (Gadamer, 1975: 271)

Gadamer attempts to provide us with a more 'open' conception of our understanding of prejudice, pointing out that prior to the Enlightenment period it was defined simply as 'judgment that is rendered before all elements that determines a situation has been finally examined' (ibid: 273). The Enlightenment was a European intellectual movement in the late seventeenth and eighteenth centuries – coinciding with the scientific

revolution – that emphasised reason and individualism as a means for gaining understanding rather than from traditions. It was only after the Enlightenment that the word acquired its negative connotation. This is what we have come to understand today. He gave a historical account of why, during this period, prejudice was discredited. His reasoning was that through the scientific revolution, scientific methodology was beginning to be understood as a means of obtaining truth: 'the only thing that gives judgment dignity is its having a basis, a methodological justification' (ibid: 273). He was critical of modern science's adoption of the idea of method, which was founded on accepting nothing as certain that in any way could be doubted.

> If we were to do justice to man's finite historical mode of being, it is necessary to rehabilitate the concept of prejudice and acknowledge the fact that there is legitimate prejudice.
>
> (Gadamer, 1975: 278)

Gadamer's main argument for prejudice as a condition of understanding, which was consistent with his ideas on hermeneutics, proposes a dialectical movement that arises as we are involved in conversation – the way in which our expectations 'open' us up to the issues in such a way that they have the potential for revision. This enables us to gain understanding. However, just because our prejudice is particular to our ways of thinking does not mean that the prejudice itself should not be taken seriously. Dalal suggests that

judgments that are central to one's thinking are by no means exempt from interrogation, challenge and question (Dalal 2012: 225). All interpretation could be considered as pre-judgmental, in the sense that it is always based on our history and traditions but oriented in our present experience. In other words, we can only form a judgment in conversations with others. In the course of interplay of conversation, meaning arises in a dialectical process that at the same time changes the judgment and contributes to understanding. This prejudicial character of understanding means that whenever we understand, we are involved in conversation that encompasses both our own self-understanding and our understanding of the issue. Therefore, in our process of understanding, our prejudices become apparent, which open us up to what is to be understood and at the same time become evident in the process. As our prejudices are revealed to us, they can at the same time also become the focus of questioning in their own turn.

Reflecting back on the conversation with Ivana, the prejudice of engaging and working with the hospital arose from my first negative experiences of working with doctors in my early career. Successive years of working in the community reinforced the positive characteristics that I associated with community working, but at the same time disabled my ability to change the way I thought about the hospital, and supplied me with no memorable positive experiences of hospital working that might challenge this understanding. It was not until I met with Dr Saeed and Dr Wilson that

my prejudice against hospital doctors was revealed to me. The hospital doctors' shared prejudice against community staff, particularly Durren staff, opened me to this knowledge about myself and revealed a situation where I wanted to defend the community while also seeking to secure the cooperation of hospital staff. This dilemma inhibited my ability to respond openly and sincerely, and my continued silence enabled the doctors' prejudice about the community to go unchallenged.

As discussed earlier, the traditional discourse views prejudice as a problematic and unacceptable way of thinking. Gadamer, however, carefully distinguishes between 'legitimate' and 'illegitimate' prejudice. Considering illegitimate forms, he talks about traditional views of prejudice as being a narrowing of one's views that obscures understanding, and refers to Schleiermacher's description as an 'over-hastiness' in rejecting the truth (Gadamer, 1975: 279–280). So, for example, at the stakeholder meeting, there was an over-hastiness to reject any community working as evidence-based practice because hospital staffs' assumptions that the community failed to keep good data. The Wyth GPs were over-hasty to reject good work that Durren may have done, which Wyth ascribed to lack of appropriate funding. Equally, the Durren GPs could be seen as over-hasty in rejecting the notion that quality is not always about money, in assuming that the Wyth GPs were only able to provide quality health care because they had more funding.

Gadamer also reflects on partiality of individuals, which he describes as 'one-sided preference for what is close to one's own sphere of ideas' (ibid: 280). I recognise this in my acknowledgement of my own sense of denial about hospital care, as well as in my own conditioned values and normative judgments – based on my predominant experience of working in the community; and to a certain extent my individual opinions about doctors in general, which have formed without ongoing experience of interaction. This is in contrast to thinking about prejudice in a generative capacity in that understanding emerges from, rather than avoids or denies prejudgment. In thinking about organisation, the Gadamerian perspective makes a strong argument for not prejudicing ourselves in our understanding of the term 'prejudice', to not think about it in illegitimate ways (described below). In a social context, we would consider conversation as a useful means for enabling us to better identify those prejudices that create a problematic influence on our understanding. He asserts that rather than assume it has no place in organisation or ignore the fact that we all have prejudices, we could be limiting our potential for transformation if we do not enable them to be revised. This requires us to think of the concept of prejudice not as a way or excluding or invalidating but as a condition for understanding.

Gadamer's prejudice

Gadamer tries to distinguish 'legitimate prejudice' (Gadamer:278) from others by asserting that other forms of prejudice can fail to allow for

‘completeness’ of understanding the text. By text, Gadamer is referring to an act, or social practice of something that needs interpretation that has a sense of wholeness for example this ideal view of ‘integrated care’. They can also fail to reveal a possible truth for an understanding about ourselves (ibid:294). Traditional ways of thinking about prejudice can close us to our thinking in the much broader sense of context. This leads me to question how I would view legitimate prejudice. What does Gadamer mean by this sense of completeness and a revelation of understanding, while we may be allowing illegitimate prejudice to dominate our thinking or distort our understanding? Gadamer’s view on prejudice is at odds with the opposing position of prejudice in the way that we understand as rational knowledge in a postmodern sense. However, in considering the benefit of the legitimacy of the way we think about prejudice, in Gadamerian terms, we may be able to have a broader discussion on social issues within organisations.

By ‘prejudice’, Gadamer understands any interpretation of meaning that positions or orientates us towards action. I as a manager would tend to approach action in a particular way based on my training, my background and the traditions to which I was affiliated. When I discuss Schein’s views on how leaders can influence culture change, I refer to the fact that he typifies a management way of thinking about organisations that aligns with systems thinking and would position the leader outside of the processes of change. This is in contrast to complex responsive processes, where leaders

and managers are understood to participate in and are part of interactions and relationships. As a manager, I made certain assumptions about the behaviour of the doctors – assumptions that preceded our encounters and our responses to those encounters.

According to Gadamer, this preceding response or pre-understanding as a form of prejudice signals its relation to the historical situation from which it emerges. Gadamer's reliance on understanding certainly undermines traditional discourse that appeals to objectivity, which sets limitations on method in the way that we think. However, prejudices are not just simply subjective interpretations of the meaning of actions or others' social norms; Gadamer insists that prejudice illustrates the extent to which all our anticipation and expectations of meaning are linked to the experience we acquire from history. For example, I describe in my narrative how both hospital and community had very different ways of delivering health care that developed from differing cultures. My own strong managerial history with community meant that I felt more sympathetic to, and familiar with, their ways of working. So in effect, my prejudice emphasised the extent to which my anticipation and expectation of this idea of 'integrated care' were embedded in expectations acquired not only from my history with the community, but also from my training and education and from what I had inherited from the culture and traditions to which I belonged. Here, I surmise that prejudice firstly comprises familiarisation with that which we

are trying to understand, because without this sense of familiarisation we would have no understanding. Secondly, prejudices reflect the culture and traditions we have participated in, which provide some sort of framework in our attempts to realise meaning.

My expectations of integrated care enabled me to understand it in a certain way; but this pre-judgement, which Gadamer describes as a provisional or proxy judgement, may not adequately reflect what we as an organisation, made up of many different groups, were trying to understand. I made an assumption about integrated care that resonated with the ways of working in an environment that I was familiar with, but did not resonate with others at the stakeholder meeting. When Gadamer calls for a 'rehabilitation of prejudice' (Gadamer, 1975: 278), I interpret this as pointing to the fact that my way of thinking would need to change, as I come to experience different aspects of the idea of integrated care. So how are we supposed to distinguish between that which is legitimate and that which is illegitimate if as Gadamer suggests, illegitimate prejudice blocks our ability to gain true understanding?

Hermeneutic circle and paradox

In thinking about an ideal as an imagined whole, one way Gadamer attempts to make the distinction is by referring to Schleiermacher's hermeneutic circle (1768–1834), which he subsequently revised as a dialectical movement of understanding in conversation. He explains the importance of

the interpreter in the process of interpretation. In a situation of our understanding of the imagined whole, when we have an experience, we can only understand this experience with reference to other people's experience and in turn our understanding of our own experience. This in effect is paradoxical, in that our encounters with this ideal view of integrated care – our understanding of each part – are based on our understanding of the whole, including the cultural and personal context. However, we can only build up our understanding of the whole and its context through our understanding of the various parts from which this ideal is constructed.

Initially, our understanding of the whole is made up entirely of prior expectations, our prejudices that we bring to our encounters with this ideal we are trying to make sense of. Paradoxically, it is these prejudices that make understanding possible in the first place; and yet these prejudices are at the same time major impediments to our understanding. Furthermore, this paradox is fundamental to not only our understanding of integrated care, but also our coming to know novel situations or others.

If I take this thinking a step further and consider this from a complex responsive process perspective, I would suggest that even though we have an understanding of the whole, that whole changes with each successive encounter or conversation we have with each other; so that our interpretation of the parts, and our sense of the whole, are subject to a continuous process of change. The idea of integrated care changes, and at

the same time our interpretations of its various aspects are dependent on our understanding of this emergent whole. The paradox here is that the idea of integrated care is informing our understanding while at the same time being formed by our emerging understanding.

In Gadamerian terms, understanding is always co-determined by the expectations (prejudices) of one interpreter fusing with the expectations of another. There are varieties of interpretations of hermeneutic circle, but for Gadamer this circular process is iterative. In the context of my narrative, I have anticipated meaning for integrated care; I then try to anticipate meaning for others, which will resonate with my own expectations. In the process of doing this, I have to revise my original experience and find an interpretation that now takes into consideration both others and my own expectations. Therefore, our new envisaged understanding of integrated care can only proceed having made sense of the developed meaning and coherence of previous understanding. This is part of what Gadamer refers to as 'fore-conception for completeness'; he proposes that 'only what constitutes this unity of meaning is intelligible' (ibid: 294).

I now recognise that any understanding is inevitably prejudiced, because it is embedded in certain experiences and assumptions that shape my initial interpretation of 'integrated care'. Nevertheless, in working out the meaning of the idealisation, others and I must make interpretive decisions about which parts are important and which parts are not important

to the meaning of our idealised whole. We would do this by evaluations. For example, does integrated care require doctor-led services, or could a nurse lead the services? Should integrated care be delivered in hospital, or should it be delivered in the community?

These are all aspects of decision-making that would fit together to make a unified meaning. In order to achieve this understanding, we must first access that which we do not understand. We do this through our initial reckoning or estimation of meaning that we bring to it, which we then explore and negotiate in our interactions with one another. We orientate ourselves to particular meanings, which in engaging with them would be revised. Thus understanding develops out of a particular focal point, recurring to particular assumptions and reflecting certain interpretive decisions.

Are we not then in danger of polarisation to think of prejudice as legitimate and illegitimate? Gadamer's answer to this is that only through critical examination can we make the distinction (ibid: 267), adding that 'Understanding realizes its full potential only when fore-meanings that it begins with are not arbitrary' (ibid: 270); but I wonder if Gadamer is being somewhat dismissive in suggesting that traditional ways of thinking about prejudice is arbitrary. If by 'arbitrary' he means subjectivity or personal bias, does that mean my prejudices were invalid because of my partiality to the community ways of working and my feelings towards the doctors?

Traditional discourse tends to overlook people's personal prejudice in favour of techniques that purport to enable groups to feel some sort of unity if we can just communicate idealisations in the right way by appealing to people's sense of doing the right thing.

History and tradition in relation to prejudice

Prejudices, irrespective of whether they are illegitimate, are, still historically situated, and I cannot see how they can be considered arbitrary – particularly if Gadamer argues that adequate understanding of meaning requires not only orientation provided by our own prejudices, but a recognition that we are prejudiced, and that our prejudices attach to traditions of understanding that pre-orientate us to that which we are tying to understand. Certainly, his criticism of the Enlightenment, which dominates traditional management thinking, is that it considers all prejudice illegitimate and therefore does not permit this term to be recognised as a legitimate method to understanding based on 'over-hastiness' in thought and an uncritical attitude towards tradition. In distinguishing between legitimate and illegitimate prejudice, we should not assume that all prejudice is illegitimate; rather, we must acknowledge that all understanding of meaning is a form of prejudice.

As I reflect on my narrative, I can begin to see this movement in thinking that reveals to me my own prejudice. I was partial to the

community; but as I come to understand what Gadamer is saying, I am reflecting on my reflections and my thinking is changing as I write; I am becoming reflexive. What I surmise is that, as far as we are conscious of the influence of our history and traditions, we acknowledge the roots of all our views and all our assumptions. We should therefore be prepared to check them by exposing and critically examining our prejudices. I now understand that my prejudice is revealed to me in the process of trying to understand the content of my actions, which I recognise as possibly different from my expectations about it. More importantly, I recognise its possible difference from my expectations by acknowledging that I might employ it to understand the issues it poses. Attempts to understand the meaning of prejudice become tests of our own prejudice. So I might put myself 'at risk' or 'into play' (ibid: 299) by exposing or illuminating them.

How, then, do I link this to my narrative? It may be that by remaining silent, I enabled doctors to reveal their prejudice. I could easily have dismissed what they were saying as wrong or insulting. However, the insight into their thoughts gave me a better understanding of what the issues meant for them and how contentious this idea of integrated care was. That is not to say that I suddenly became sympathetic to their ways of thinking. Similarly, putting myself at risk by inviting the patient to speak – not knowing what he would say, but knowing when he had made his statement that I had revised my thinking as his expectations were revealed to me. In

my rethinking of the situation, I was unifying the patient's expectations with my own – a process that Gadamer describes as 'fusion of horizons'. By 'horizons', Gadamer means the linguistic concepts through which we understand the world. It is itself a constant possibility for the historically effected consciousness to gain further self-knowledge through the experience in language as historically and temporally defined phenomena. This concept will be discussed further in the synopsis. For now, it is important to make the point that for Gadamer, understanding comes from a fusion of horizons. Every encounter with tradition takes place within historical consciousness and involves the experience of the tension between the text and the present; or the experience of prejudice between my understanding of integrated care within my historical consciousness and the experience of prejudice in the present context of understanding integrated care.

Expectations of our expectations

Mead (1934) presents an interesting alternative view of expectations, describing how human beings can only recognise ourselves through interaction with others; our social selves are emergent (Mead, 1934: 198). For Mead, conversation is the conduit of emergent reflexivity and the process of socialisation (ibid: 134). It is through conversations that we establish ourselves in relation to others. Language is understood as a set of gestures that structure the expectation/response of action between two

individuals. There is a difference between what is spoken verbally and what is acknowledged silently in our thoughts. Through the internalisation of our expectations, activities emerge through which I might respond to another individual, while at the same time anticipating their response to me. The meaning of the gesture appears between these expectations and responses. In contrast to Gadamer's view of alignment of expectations ('fusion of horizons'), Mead suggests that the action is simultaneous and co-created; thus, it cannot be characterised by a single agent.

In conversation, our ability to react to ourselves is not only a mutual interchange of expectation/response, but also an interchange of expectation/response with oneself – gradually 'taking the attitude of the other' and becoming self-reflexive. Gadamer argues that prejudice is a condition of understanding, emphasising its historical authenticity; but Mead, while acknowledging this, does not consider prejudice itself a sufficient condition for the ability to self-reflect. Mead stresses the importance of considering temporality: 'The past is both irrevocable and revocable' (Mead, 1932: 2). The past is always reformulated in the light of the emerging present. History is irrevocable, but our interpretation of the meaning of history is always open to question and reinterpretation. Thus, for Mead, the experience of the present is irrevocably linked to the past, and conditions what emerges in the future. My prejudice, which has a historical context, can only be characterised by the demands of my present

understanding as I anticipate the future of my expectations of my expectations. This can only be realised through the social process of conversation.

Traditional management ways of thinking, such as those proposed by Schein, tend to be dogmatic – imposing meaning, rather than allowing the 'text' to be revised by allowing 'otherness' to provoke critical self-reflection. Schein thinks from a systems perspective, which seeks objectivity and asserts the importance of the individual's ability to influence the group. From a Gadamerian perspective, by contrast, every experience invites openness to otherness: 'Every experience worthy of the name thwarts expectations' (Gadamer, 1975: 356). Equally, from a Meadian perspective, understanding arises from the process of social interaction in which the individual does not take priority over the social.

This social awareness contrasts with how I was expecting to act as a manager. My intention was to take a systemic change management approach by engaging with key people in an attempt to influence them into sharing my way of envisioning the strategic direction. The meetings with the doctors and the stakeholders were designed to reduce any form of resistance by ensuring 'buy-in' from all the groups involved; I hoped to downplay any contentious issues. However, this way of thinking about prejudice has been a way of making sense out of that which we are trying to understand. When we are confronted by prejudices that are orientated by

history and tradition, we must accept that prejudice might be exposed to the extent that we put ourselves at risk in trying to gain understanding of others.

Gadamer suggests that we should not be prejudiced towards our prejudices. To think of prejudice illegitimately can paralyse one's thinking, disabling our ability to critically self-reflect. We naturally encounter challenges to aspects of idealisations that we have assimilated within our own ways of doing things, and which will lead us to experience the world in particular ways. Thinking in a wider context regarding organisation, it seems that managers are encouraged to be objective and to set themselves 'outside' the processes of managing change; but in reality, I could not detach myself from the experience of prejudice. Our understanding is formed by, while at the same time forming, our prejudices as these are continually iterated and revised in our ongoing relations with others; it is important to acknowledge this if we are to understand the nature of change.

Conclusion

My thoughts on integrated care are born from a particular abstract idealisation of what this is, which itself is born of a particular set of values and the assumption that any appeal to our liberal sensibilities will evoke similar enthusiasm from my NHS colleagues. As individuals, we cannot detach ourselves from the history and traditions that enable us to identify with a particular group; we must take into account that others are similarly identified. We inevitably adopt a prejudicial approach that makes the

distinction between ourselves and others, affirming our sense of self and our identity with the particular group. Organisations tend not to acknowledge this aspect of prejudice, viewing it as a problem that must be eradicated as though it has no place in our movement of thoughts and our sense of understanding. From a Gadamerian perspective, I now see that it is more helpful to recognise the part that prejudice plays in the ongoing emergence of understanding.

Gadamer insists that the 'essence of the question is to open up possibilities and keep them open' (Gadamer, 1975: 289), and explains that if our own prejudice is challenged, we should not necessarily discard it in favour of other views.

According to Stacey, organisations are notions of habits, customs, traditions, routines, mores, norms, values, cultures, paradigms, beliefs, missions and values (2011: 344). From a complex responsive processes perspective, I am proposing that prejudice is a thematic pattern that organises our experience of being together and creates the potential for transformation, if we think about it in a way that opens our thinking and draws on our sense of authenticity.

What I conclude is that to be 'prejudiced' – in the context of trying to bring groups together – is simply to accept without judgment our sense of belonging to a group, while at the same time acknowledging that this represents our difference from 'other' groups or individuals. We form

opinions about others all the time, which can only be based on assumptions in the absence of direct experience. Within an organisation, our interdependent relationships are inevitably influenced by such prejudices. This is an important aspect to understanding our potential to change: we orientate ourselves to particular meanings, which in themselves can be revised, but which nevertheless offer a starting-point, recurring to particular assumptions and reflecting certain interpretive decisions.

When we are confronted by others' prejudices, which are equally orientated by history and tradition, we must accept that our own might be exposed. In order to transform, we must put ourselves at risk: mutually sharing our ways of thinking in order to broaden the experience on which we base our views – a dialectical movement through which all new understanding is reached.

Synopsis and critical appraisal

> 'Without the aid of prejudice and custom, I should not be able
> to find my way across the room.'
>
> (William Hazlitt, 1778–1830)

Purpose

The purpose of this synopsis is to re-examine why middle managers find it problematic implementing strategic directives into practice, and how they respond to resistance and prejudice. Here, I aim to clarify my argument and review my position to date by reappraising and critically reflecting upon the development of my understanding from my previous four projects, drawing attention to particular themes that have emerged. I will also be reflecting on methods employed during the course of the research, which have encouraged me to develop a reflexive way of thinking and provided me with another perspective for making sense of my experiences in the organisation within which I work. In paying attention to the experience of the emergent themes, I hope to demonstrate how my thinking has changed from when I first started on the DMan programme. The synopsis will be written in four parts:

- Part 1: Reflections on previous projects and changes to my practice

- Part 2: Reappraisal of emergent themes and how my thinking has changed
- Part 3: Understanding the research method and the importance of reflexivity
- Part 4: Contribution to knowledge and practice.

Part 1: Reflections on previous projects and changes to my practice

Opening remarks

The next sections are summaries of my four projects in which I will be drawing attention to the key themes that have emerged through the ongoing process of reflexivity, which I will discuss further in the method section. It has been interesting to reflect back on my previous projects to see if there have been any changes to my ways of working. At the time of writing each project, I was not aware of making any obvious changes to practice; perhaps I was still anticipating an outcome to my research. But with the passing of time, the pieces of the jigsaw have begun to fit together into something quite unexpected. Looking back now, I can see that tiny, incremental changes to my practice have somehow revised my expectations for each successive project. I am in no doubt that this will have influenced my reappraisal of key themes.

Project 1

Project 1 gave me the opportunity to explore my earliest recollections of working within an NHS environment. I was also able to look back on how my career had progressed into a middle management position. Those early days starting out in management gave me my first experiences of things not going to plan, despite processes in place to try to manage difficulties with staff or with the clinical care provided. I had attended numerous training courses that were supposed to equip me with the skills to manage more effectively. But it soon became clear that leadership skills and competencies did not adequately prepare me for the conflicting and contradictory situations that I encountered. Often, I came up against conflict and resistance when implementing a change. Nevertheless, I continued to believe that the skills I had acquired through training, coupled with my personal attributes, would enable me to control and influence the staff I managed. To my dismay, this was not always the case.

As I reflect back, I think that I had a particular view of ways things should have been. Even throughout my research, I still found myself back in organisation promoting the very things that in my projects I was trying to argue against. What I understand now is that expectation about 'taken-for-granted' management practices had limited my ways of thinking; this became apparent to me when trying to implement strategic directives into practice. Even at the time of writing Project 1, I had some fixed notion of

my roles and responsibilities as middle manager and an expectation of what I was required to do. Learning organisation theory influenced my practice; authors such as Davies and Nutley (2000) typically advocated that individual and team learning could enhance personal capabilities. Much of their work was drawn from systems thinkers – such as such as Senge (1990), who believes that innovation in learning organisations can be achieved through systems thinking, personal mastery, mental models, building shared vision and team learning; Argyris and Schön (1996), who understand learning at different levels and illustrate how acquiring learning strategies and information skills can enhance learning capacity and flexibility; and Mintzberg (Mintzberg, 1994; Mintzberg et al, 1998), who advocates building organisational culture to manage change. These authors for me typified an approach to leadership and management that leans towards the importance of an individual's capability and competency to manage change.

Changes to my practice – no taken-for-granted assumptions

I have been wondering whether I brought any of my insights from Project 1 into practice in any tangible ways that I can relate, and have concluded that one clear change was that I became less accepting of 'taken-for-granted' assumptions about management practices. Of course, this did not stop me from continuing to use processes, tools and methods in my daily work: I still had to work in an organisation where such activities dominated the

everyday life of a manager. What changed for me was the realisation that there exists a different perspective to systems thinking in management – one that takes account of what happens in relationship between individuals and what might arise from their interactions, rather than focusing on the importance of the individual.

Project 2: A middle management perspective on the processes of responding to strategic directives in an NHS organisation

NHS Durren employed me in early 2010, as a general manager of three community clinical services; I was also the professional lead for Nutrition & Dietetics. My role was to implement strategic directives and ensure that services were performance managed to meet the targets set by the organisation and by the Department of Health. As a middle manager, I often found myself straddling the boundaries between the executive management team who formulated strategic directives and the frontline staff who had to carry out these directives. The problems I encountered were firstly, trying to understand what the strategic directives meant in terms of day-to-day operational instructions; and secondly, communicating this to staff in a meaningful way that emphasised the need to join up care by integrating ways of working. However, there was also an expectation on the part of our executive team that integrating services and ways of working would provide more efficient and cost-effective care for patients. One way in which middle managers approached this was by restructuring services, which was seen as

a way of facilitating integrated care. Another was to develop integrated care pathways, aimed at encouraging teams to work together to provide consistent clinical care. I frequently used the technique of clinical engagement through stakeholder meetings to try and bring teams together using a planned agenda, then to systematically work through processes of gaining consensus. I took for granted the assumption that, as a manager, I could influence and control this process of change simply by having the right plan of action in place.

The problem with this way of working was that I took no account of the fact that we had three organisations that had just integrated into one fairly rapidly (within 12 months). Staff did not understand what was going on because as the executive teams were forming, so the strategic directives were continually changing. It became increasingly difficult to communicate by cascading information through the organisational structure when the whole organisation was integrating. Trying to implement the strategic directives created very tense and emotive situations for staff and myself, because we were all interpreting them very differently based on our previous ways of working. Nevertheless, I and my other colleagues considered these to be a fixed set of instructions handed down from the most senior management teams, to be actioned without question. Whenever something unexpected happened, however, we found that our communication approaches did not go to plan.

I felt that Project 2 needed to be an exploration of how middle managers were responding to this ever-changing situation. The narrative I used was an example of how the strategic directives changed frequently in the course of the organisational restructuring, and the dilemmas I faced in trying to remain objective when a colleague Priya, who was also my friend, was demoted as result of this process. In my reflections on this narrative, I began to understand the extent to which my thinking was influenced by systems theory. I thought it was important to describe the environment in which I worked as one where hierarchal decision-making – such as I experienced from the executive management team – broadly reflected my understanding of the way the NHS operated generally. However, like many of my other manager colleagues, my training was based on learning organisational theory.

The dilemma I faced was that I was privy to conversations at executive level regarding Priya, but felt unable able to discuss these plans with her because, as a result of her demotion, she was not technically part of our middle management structure. Communication plans informing staff of changes within the organisations were carefully constructed in the belief that if managers explained these changes clearly and effectively, then staff would be more likely to comply with them. This linear way of thinking typified my understanding of organisational management approaches such as communication plans and the idea of cause and effect. I spoke in Project

1 about my practice as a dietitian being influenced by empiricism, which derives from the natural sciences 'focusing on cause and effect links having an efficient causal "if-then" structure… This causality assumes the laws of nature produce certainty and in the case of efficient cause enables reasoning humans to predict and so control nature's movements' (Stacey, 2010: 31).

According to Stacey, this notion of certainty has transposed into organisational management and become a dominant way of thinking, with rational individuals expected to control and influence events and situations (ibid: 31). Yet, despite espousing this view myself at the time, I experienced tensions between Priya and myself, arising from the ways in which we were making particular the strategic directives and communicating them to one another. I could not predict Priya's response, nor indeed anyone's; but I was expected to liaise appropriately in accordance with the communication plan not only within my services, but also with Priya. This required us to dissociate ourselves from emotional responses, which was impossible within the context of our friendship. At the time, I concluded that traditional management communication approaches of cascading information and being selective of the information to be shared were unhelpful in understanding the process of change.

Changes to my practice – reflecting on the theory of complex responsive processes and paying attention to the experience of what we actually do in our interactions with others

What changed for me during the course of writing Project 2 was a shift in the way I was now thinking. I was less complacent about making assumptions that traditional management practices were the only way of viewing organisations. In understanding the theory of complex responsive processes, I was able to consider organisations as patterns of interaction between people rather than discounting the effects of human interaction and emotions, which so many organisational management approaches seemed to do. I could now see how the systemic view of communicating information to frontline staff and cascading this down through the organisational structure did not take into account the uncertainty of people's responses. It became clear that my own relationships with colleagues were not based on anything predictable, certain, or straightforward; yet I still believed that as a learning organisation, working in teams, we could aim to influence the bigger picture.

Changes in my practice arose through reflecting on my assumptions and challenging them. I have been able to share with certain colleagues the critical incidents in my narrative that have been problematic in making particular the broad generalisations that I understood as strategic directives. I concluded that control and influence could not be taken for granted, just

because we had plans in place; and that strategic directives could not be considered as fixed rules and instructions. I was having many conversations with my managers and colleagues, who in turn were having conversations with their own managers and colleagues. Strategic directives emerged in our interactions with one another. I am much more aware of paying attention to the experience of human interaction as a social process, rather than focusing primarily on the individual as taking priority over the social group. This shift in my thinking has come about through self-reflection – which includes my involved interaction with others.

Project 3: How middle managers in the NHS respond to translating strategic directives into practice and the experience of resistance

By mid 2010, changes in government policy culminated in my organisation integrating with a neighbouring community health trust and a hospital trust. This new organisation was seen as the way to improve continuity of care for patients when they were discharged back to their homes from hospital. It was also seen as an opportunity to streamline management structures. To achieve this, all management posts were to be restructured within a short timeframe. Such extensive restructuring caused a high degree of anxiety among staff as all the managers jostled to position them in readiness for integration. It was left to the middle managers to implement the process of integration and restructuring, all the while not knowing whether they themselves would have a job in the new organisation.

Project 3 focused on my relationship with two senior and a group of junior physiotherapy managers, trying to work together in the midst of this integration. I was interested in exploring how I was responding to the current strategic directives resulting from higher-level planning, which involved organisational restructuring, and integration. Looking back on the situation, I had formed a poor relationship with the two senior managers – Jack and Jim – and a good relationship with the junior physiotherapy managers. But I questioned what effect this was having on our day-to-day interactions with one another. I looked at this as an example of patterns found more widely in the NHS, where the imposition of strategies of integration shifted patterns of power relations and threatened people's identities. I now acknowledge that this has an effect on how we behave, particularly when managers themselves are supposed to be in control of local interactions while at the same time experiencing threats to their own positions. In relating this back to Project 2 and my relationship with Jack and Jim, the difficulties we were experiencing and what I perceived to be their resistance seemed linked to the way that each of us were making sense of and particularising the directives; but at the time, I felt I was trying hard to understand and manage their behaviour.

In reflecting on this pattern of behaviour, I came to realise how much of the way we behave had to do with the way we interact with one another and the interplay of our intentions. It struck me that the way I was

thinking about my management practice at the time was associated with my belief that effective middle management depended on skills, competencies and personal attributes. I drew on the views of Alistair Hewison, who in *Management for Nurses and Health Professionals: Theory into Practice* (2004) emphasises the importance of understanding the role of middle managers more fully by recognising the level of influence these individuals can have within the organisational structure. As I reflected on this, I felt that I, as an individual, was in a position of influence, which carried with it a sense of autonomy, power and control over the people I managed.

In critiquing this idea of the autonomous individual manager, I drew on the work of Farhad Dalal, a group analyst (1998), who believes that priority should not be given to either the individual or the group; this challenged my way of thinking about my relationships with my staff. Norbert Elias' views are also taken up in the theory of complex responsive processes, as well as by Dalal in his exploration of interdependence. Challenging my ideas of power being located with the individual, Elias considered power to be structural characteristics of all human relations because of human interdependence (Elias, 1978); he proposed that power is not a force within individuals, but should be viewed as differential and relational. Based on my own interactions, I concluded that the relational aspects both constrained and enabled at the same time and were co-created through local interaction because of our interdependence.

This enabling and constraining relationship emerged as patterns of inclusion and exclusion, which also affected the way I interacted with staff. For example, I had assumed that Jack and Jim's refusal to actively participate in a clinical engagement meeting demonstrated their resistance to change; but what I subsequently came to understand was that this resistance was emerging through our interactions with one another. So when I talk about a power figuration of enabling and constraining, my action – including them in a meeting that they did not want to be part of – constrained them, but at the same time enabled them to resist through non-participation, thereby excluding themselves. Resistance was not intrinsic to them, but a response to how we were relating to one another; it was certainly something I was not prepared for.

I found James C. Scott's views on resistance (1990) helpful in understanding the emergence of resistance. Scott offered another way of considering this which coincided with the way I was beginning to think about it from a complex responsive processes perspective – that is, as a normal part of local interaction that emerged from figurations of power. He discussed how people blocked, subverted and countermanded in hidden or discreet ways under hegemony. Processes of resistance are understood in terms of Scott's distinction between the 'public transcript' and 'hidden transcripts', as well as in the interplay of our intentions. Scott used the term 'public transcript' as a way of describing the official story: 'It is the open

interaction between the dominant and subordinate, and is action that is openly avowed to the other party in the power relationship' (Scott, 1990: 2). 'Hidden transcripts' are covert actions that resist the official story – such as gossip, collusion and use of euphemism. I concluded that resistance was co-created, a response invoked through the ways in which we enabled and constrained each other as we sought to protect our identities, which felt under threat. This insight supported my thoughts about resistance being located as social processes of local interaction and emerging from figurations of power that both enabled and constrained relationships.

Changes to my practice – thinking about resistance located as a social process

By the time I had completed Project 3, I found that I was not so quick to assume resistance as a characteristic of individual behaviour – despite the fact that my organisation, in its change policies, still referred to it as such. What has emerged is an understanding of the importance of the social in relation to my previous thoughts on individuality. I find that I am more attentive to my own behaviour, and more ready to reconsider how we are all participating in interaction, rather than to assume that problems are located with the individual. However, this attention does not necessarily result in reducing resistance. I have come to understand that power figurations and enabling and constraining relationships are inevitable processes within a social context. Thinking about resistance as emergent in the interaction

offers a way of knowing how we are able to carry on relating to one another; this requires us to be able to explore our differences and similarities as we compete and cooperate in the workplace.

Project 4: Understanding integrated care and the experience of prejudice

This project was a culmination of my thinking in further consideration of middle management roles and taking up the issue of how we respond to translating strategic directives into practice. My narrative focused on a situation in which I had to integrate services across hospital and community. My goal was to bring teams together to start engaging with one another, and to communicate the NHS vision for integrated care. I had assumed that most staff would agree that integrated care was a good thing for patients, and so would cooperate in developing pathways. However, I was unprepared for the level of hostility that surfaced between hospital and community staff during their first encounter at a stakeholder meeting. As a manager, I was still trying to remain objective and taking an individual approach to managing the situation, despite beginning to grasp the significance of complex responsive processes as a way of understanding what was happening.

Two things surprised me in writing my narrative. Firstly, that the theme to emerge was prejudice as I considered the thoughts and feelings that staff in the community had towards the hospital and vice versa, which manifested as open hostility towards one another. Secondly, that in the

process of self-reflection I revealed my own prejudice towards hospital staff and a sudden revelation that this would inevitably affect the ways I would interpret the meaning of 'integrated care'. Of course, in using the term 'prejudice' I understood this at first in the traditional sense (used in organisations) with its connotations of bias, bigotry and discrimination against individuals and groups. However, in my exploration of prejudice, I was interested by Gadamer's hermeneutic approach in thinking about prejudice as a condition of understanding. In his book *Truth and Method* (1975), Gadamer describes prejudice as a precondition of the movement towards understanding, explaining that the negative connotations of the word are relatively recent (post-Enlightenment); he suggests we consider prejudice as a legitimate term that encompasses our *expectations of meaning*, and as a process that opens us to critical challenge through which understanding is reached.

I became aware that my anticipation of how we would work towards integrated care were embedded in the expectations acquired from my history as a community manager – prejudices that reflected the culture and tradition I had experienced over 10 years. To have these expectations, based on my past ways of working, cannot be considered unreasonable; to declare them 'prejudice' in a pejorative sense, using the negative connotations that are typical of current literature, would have been unfair. I now recognise this as an underlying theme throughout all my narratives; part of my research

method has been challenging some of my prejudices and revising my understanding over time, generating a gradual evolution in my thinking. In my reappraisal, it is important for me to consider how we might think about prejudice as a necessary process to transforming the way we are thinking; I will reflect back on Gadamer's hermeneutic understanding of it as a necessary process, which I will raise as both method and theme.

Changes to my practice – thinking differently about prejudice and reflexivity

I had some concerns that had it not been for the process of reflecting back on my narrative, engaging with my reflections and rethinking the term 'prejudice', I might have missed valuable insights to be gained from a more detailed examination of some of the interactions I had experienced. However, the process of reflecting back has enabled me to see how productive it has been to iterate these projects and revise my thinking in the development of understanding. The changes to my practice, following on from Project 4, have not only been about my attempts to understand the term 'prejudice' in a broader context, but – more importantly – noticing differences in the way I was thinking in the past and how I now consider my thinking in relation to others. I have found that individual and social cannot be separated; it is important to keep 'noticing and thinking about the nature of our involvement in our participation with each other as we do something together' (Stacey, 2012: 112).

Part 2: Reappraisal of emergent themes and how my thinking has changed

Theme 1: Paradox – particularising of strategic directives

First argument: We cannot implement strategic directives as if they were an unchanging set of instructions that requires literal interpretation.

Opening remarks

This section draws out the key themes from my projects; I begin to answer the question of why I experienced difficulty in implementing the strategic directives. I will present a way of thinking about these instructions as generalisations, and the problems I encountered; and also bring in the theory of complex responsive processes to help make sense of my current understanding of the paradox that in our particularisation of strategic directives, they are informing our understanding and consequent actions (those of us involved in local interaction) while at the same time being formed by our emergent understanding and local interaction.

I review George Herbert Mead's thoughts on universality of response and re-examine the connection between generalisations and expectations of meaning in my reconsideration of the term 'prejudice'. In doing so, I hope to draw attention to strategic directives as simplified and abstracted articulations of conversation. I also discuss how we make particular those generalisations in our conversations with others,

highlighting the process of particularising as one of exploring and negotiating – and, more importantly, emerging in local interaction.

A complex responsive processes perspective on implementing strategic directives

Reflecting back on past projects, I initially saw the strategic directives as a form of locally set instructions, a blueprint that the executive teams had developed for me to implement. However, these instructions seemed to change frequently, and I could not understand how the senior leaders could keep changing their minds knowing that this would create difficulty in implementation. So my plan of action was to engage with staff and try to obtain consensus on taking the directives forward; this was the very purpose of the stakeholder meetings planned in Projects 3 and 4. If staff were able to feel that they had a vested interest by conversing with one another, then we would reach consensus, and they would then be more likely to comply with the implementation.

From a learning organisation perspective, Senge (1990) recognises the importance of a manager's skills of inquiry and reflection in building teams. He argues that in influencing through dialogue, managers can bring about consensus. Dialogue based on skilful inquiry is much less dependent on the particular situation, such as whether the teams get on with one another (Senge, 1990: 231–232). But of course, in my examples, there was conflict at these meetings – manifested either as lack of participation or in

arguments between participants. The problem I have now with Senge's viewpoint, which was one I fully endorsed prior to my research, is that it presupposes that our relationships with others are linear and takes a centred approach to management, locating it with the individual in terms of personal capabilities. Despite the possibility that my skills and competencies to manage were inadequate, no amount of training and preparation would have enabled me to determine the outcome of the meetings or plan for some of the responses that occurred.

Kenneth Gergen takes a different stance, adopting a social constructionist perspective to view organisations as a 'field of conversation' (Gergen, 2009: 145), recognising the significance of conversation rather than focusing on the skills of individuals. My interpretation of his argument is that it is through our relationships with one another that we construct the world of consensus reality. In his book *An Invitation to Social Construction*, he presents the example of high-ranking managers making decisions that rarely reflect the realities and values shared in conversation (ibid: 146). In comparison with my example, he problematises the way in which instructions can be open to interpretation and advocates facilitating a dialogue – to include as many participants as is feasible – that 'mobilises collective meaning, motives and values' (ibid: 146). Those with a vested interest who can contribute are more likely to support what is created (ibid: 146). From this perspective, the relationships and importance of dialogue

are recognised. 'Constructionist dialogue celebrates relationship as opposed to the individual, connection over isolation and communion over antagonism' (ibid: 88). In this statement, Gergen has clearly created a dualism that makes it easy to apply an *if–then* causality, which rapidly becomes problematic for the individual. Nevertheless, from his decision-making example there is still something deterministic in his consideration of the importance of the social. My own experiences resonated to an extent in my actions to have some form of collective agreement or united front, but my attempts to steer the conversation again yielded something unplanned, bringing conflict and resistance into the open and revealing prejudice.

The theory of complex responsive processes offered a way of acknowledging the importance of the individual and social both at the same time, as paradoxical in relationship. This has become primary in my thinking as I begin to understand from my previous projects about the interdependencies of my relationships with others – both individuals and groups. This idea of paradox extends to how we make particular these generalisations. I find this perspective helpful because I feel it provides a more realistic explanation of what happens in organisations in the interrelationship between global patterns of action and local interaction. I could see from my narratives that I could not assume linearity in relationship with others, and that deterministic approaches did not guarantee the desired outcome. I was attempting to resolve dilemmas, trying to choose

one decision over another; and this polarisation of problems became a source of internal conflict for myself as well as a source of open conflict for others. I seemed to be forever trying to resolve contradictory situations and events that I now see as irresolvable: there was no ‘right’ way of doing things. By trying to accommodate one side, I would upset the other side and end up facing yet another dilemma.

In terms of complex responsive processes, organisations are not viewed as planned interactions with predictable outcomes, but rather as processes of human interaction where patterning in local conversation between people leads to global patterns, which in themselves affect local interaction. These processes are seen as self-organising and emergent (Stacey, 2012: 14), meaning that no one can stand ‘outside’ this process of interaction and determine what will happen – despite the leadership training I had, which aimed to provide me with the skills and competencies to do so. Organisational strategies arise unpredictably in the interplay of many different intentions; as such, emergence is not a matter of chance. What emerges does so precisely because of what all those involved choose to do or not to do (Stacey, 2011: 310). What is now important for me, as I will explore further in the next section, is that the population-wide patterns of an organisation are paradoxically being formed by local interaction while at the same time forming this interaction. In responding to strategic directives formulated by the most senior leaders, the way in which we interpret and act

on these is related to how we make particular these generalisations, which then also have the potential to shift the global pattern or to replicate it. What arises from this process is of interest, because the outcome – being contingent on specific situations which, I argue, are paradoxically predictably unpredictable/unpredictably predictable – cannot always be determined in advance and, as my narrative shows, seldom occur exactly in the way I had originally intended.

Understanding process of particularising and generalising as paradox

In Project 2, I described my situation as a dilemma: I was torn between wanting to do the right thing for the sake of patient care, and wanting to do right by my colleagues and myself. This undoubtedly affected the way that I interpreted and implemented policies in my experiences of interacting with others.

The views of Mead have helped me to understand what happens in the process of communicating with one another in conversation. He proposes that the experience of participating with one another gives rise to meaning. Mead suggests that in every experience of encounter, there is some generic character that lends it meaning: 'when there is a response to an object such as a dog, there is a response of recognition as well as a response toward the object in the landscape' (Mead, 1934: 82). I interpret this to mean that an object will call forth a universal response of recognition. We might otherwise associate the dog with a general character; it is only when

we have reason for interest in a *particular* dog that it becomes distinguishable from the object. Up until this point, our relationship to the animal is universal.

Thus, our universal response to a dog is to imagine a furry animal with a wagging tail that barks, but it only becomes meaningful when we apply some kind of context that is linked to our own self-interests. So for example, someone with past experience of being bitten by a dog, who then responds to other dogs with wariness, would not just be responding to the general idea of a dog. Just as past experiences with a dog may affect how we respond in the present and future to a dog, I would suggest that terms such as 'integrated care' have a universal character – as something that is generally accepted as a good thing for patients; but attempting to define this and have some form of shared understanding of how this translates into daily operational life led to conflict – or, in the case of the physiotherapy managers and myself, resistance; in our interactions with each other, we revealed our underlying prejudices for our own ways of working.

This particularisation is an exploratory and negotiative process towards meaning; when bringing our own self-interests into play, the universal response then answers to a whole set of particulars, which will call forth a whole different set of responses (ibid: 84). In my recollections of Project 2, I remember being frustrated that Priya did not see the 'bigger picture' in terms of the strategic directives around the need to restructure in

support of the policies for integrated care. At the time, I felt that this was not personal: the fact that Priya was being demoted was sad, but an inevitability of organisational change – this was one of my internal responses, from my managerial perspective. I hoped that distancing myself in this way would make it easier to get through this process. But of course, Priya was also my friend; so maintaining emotional distance was difficult and even, at some level, inappropriate. I was also responding to another stimulus, which reflected another aspect of our relationship.

What I glean from this is that even though responses to a set of particulars emerge from the universal characterisation of what I understand to be generalisations, they are responses that are not predictable and are contingent on particular situations at a particular time. Assuming that I can control and influence change as a manager using organisational management approaches does not reflect the experience of our interactions with others.

> If the object does call out that response, no matter what its particular character may be, one can say it has a universal character.
>
> (Mead, 1934: 83)

Mead describes what he calls 'social objects' as being constituted in terms of meaning within the social process of experience and behaviour (ibid: 77). Mead also refers to symbolisation or representation, whereby the social

object is created within the context of social relationships (ibid: 78). Thus, the meaning of ‘integrated care’ can be seen as arising in a social process of relating to one another. This is perhaps illustrated in Project 3, when I had assumed that my physiotherapy managers would welcome collaborative working with the neighbouring borough, given that we were to form an alliance. Although they had started off by scoping a possible model, they made no attempt to participate at a stakeholders meeting – which, at the time, I interpreted as resistance on their part. This clearly affected our attempts to articulate meaning.

Mead points out that language not only designates a situation or object, but also perpetuates it. In Project 4, I describe taking the risk of allowing a patient at the stakeholders meeting to express his expectations; this totally changed the nature of the meeting, in which the participants had been struggling to agree on the meaning of integrated care. This simple act, a spontaneous gesture, allowed for a window of opportunity to continue the conversation at a later date, despite not having met the outcomes for the meeting. The social process is key to this: language expressed in a conversation between individuals though gesture and response give rise to new meaning, and creates a new social object or perspective of the object (ibid: 78). In other words, social objects arise in a social process, experienced in the communication and collective organisation of behaviour among individuals. According to Stacey, they are another formulation of the

generalising and particularising process and are tendencies to act (Stacey, 2010: 163).

In Mead's terms, generalisations can be considered social objects as they represent tendencies to act arising from many conversations and are articulated into a symbolic representation that holds elements of universality from a moral standpoint. According to Mead, the position taken when judging questions that have moral relevance has to allow for the known interest of everyone involved. This is because the way we work in our groupings brings general interest into play. Mead's (1934) view was that in every interaction, we would take the attitude of 'the generalised other', which we would see as the social environment in which we live. Mead's reference to a social object was simply another formulation of this 'generalised other', which would otherwise be considered as generalised tendencies 'that are common to large numbers of people, to act in similar ways in similar situations' (Stacey, 2012: 34).

According to Stacey, the point Mead makes is that social objects are iterated in each living present as repetitive and habitual patterns of action (ibid: 34). However, the repeated expressions of the social object are taken up by individuals and made particular to the situation in which we find ourselves. The process of particularising becomes conflictual as we try to interpret meaning in our explorations and negotiations with one another, in trying to establish what the generalisations mean for us in these particular

situations. So there is the potential for the meaning to shift and our prejudices to be exposed; and in this process, something new emerges.

My interpretations thus emerge in this exploratory and negotiated process of particularising; we can think of this process as generative and transformational in that it gives rise to the possibility of spontaneous new meaning, which provokes a variety of responses from our interactions with one another. Mead approached the idea of particularising the general as a process of dynamic interaction premised on communicative interaction as conversation. This plays an important part in our understanding of self in relation to others, and is important when regarding our own interests.

> The principle I have suggested as basic to social organisation is that of communication, involving the participation of others. This requires the appearance of others in the self, the identification of other with self, the reaching of self-consciousness through self.
>
> (Mead, 1934: 233)

Throughout my projects, I have referred to the importance of presenting a united front and my own interests in delivering better patient care. But I was also concerned with how others would view me, particularly my managers. I had an expectation of how I as a manager should behave. This demonstrates Mead's point about being able to consider self as the object against which others might judge me. That is to say, how do I act in relation to how

I/others consider a manager should act in general? Mead points out that whenever the element of 'ought' is involved, wherever conscience speaks, there is always a universal form (Mead, 1934: 380). This infers a sense of obligation or constraint in the way that we act so as not to endanger the unity of the collective. However, I understand Mead's recognition of variation in responses in his signalling to the issue of an individual's own immediate interests and that our consideration is for the immediate. He stresses the difficulty in making ourselves recognise the other in the wider interest and bringing them into some sort of rational relationship with the immediate one. Nevertheless, it is human nature to be caught up in our own interests.

What is important to point out about our self-interests, from Mead's perspective, is that they are formed or realised in relation to our experiences of others, as well as in relation to ourselves as the object or 'generalised other'. We cannot disassociate ourselves from our self-interests; and this challenges the notion that we can be impartial and arrive at a reasoned judgment. Mead's 'I–Me' dialectic, which I discussed in Project 2, is an example of why we cannot separate out aspects of our self:

> The 'I' responds to the gesture of 'me', which arises through the taking of attitudes of the others. Through taking those attitudes we have introduced the 'me' and we react to it as an 'I'. The 'I' of this moment is present in the 'me' of the next

> moment. There again I cannot turn around quick enough to catch myself… It is because of the 'I' that we can say we are never fully aware of what we are, that we surprise ourselves by our action.
>
> (Mead, 1934: 174)

When we bring our self-interests into play, which I would argue also encompasses our *expectations of meaning*, is when we make particular our experience of the social object. This experience of the social object is contingent on particular situations and circumstance. This is important in considering the relationship between the general and the particular. According to Mead, it is the answering to the response to an indefinite number of stimuli (ibid: 87). We might also think of stimuli as motivations or impulses. So, for example, the ways in which I interpreted the strategic directives were not only affected by the desire to implement an instruction, but also by my relationship with my managers and wanting to prove myself a competent manager. It was also affected by the way I viewed doctors, and by my bias towards community ways of working. With this in mind, it becomes apparent that meaning continually emerges in the process of particularising, where generalisations are forming in our interactions with one another as well as being formed by those responses to one another.

The process of generalising and particularising are productive ways of understanding that are social processes, not deterministic. If we consider

strategic directives as generalisations, then we particularise these in our understanding of something universal with which we make further generalisations. In particularising generalisations, we bring our own self-interests (motivations) into play; at the same time, meaning that arises will be forming and being formed in each successive iteration in the present. Mead's way of thinking has been helpful in enabling me to understand the importance of our interactions with one another – and that particularising strategic directives is not an individual act, but a social process that is part of the social act. So the way I have developed as a manager is inextricably linked to my interactions of gesture and response with others, and how meaning emerges as part of that social act. This is in contrast to my previous ways of thinking, in line with organisational learning theory, based on the assumption that individuals and teams learning together, to enhance their personal capabilities, were better able to manage change.

Mead does not claim that generalisations take priority over the particular, but that both are at the same time mutually dependant: forming, while also being formed by, one another – a paradoxical relationship. We can see how the strategic directives could continually be iterated and not fixed; so we cannot implement strategic directives as if they were an unchanging set of instructions requiring literal interpretation. Our responses change depending on the way that we particularise, which in turn is contingent on particular situations at particular times. This is not something

that can be predicted or planned for, because there are any number of self-interests, calling forth different responses, that might account for the ways in which we particularise; and this changes with time, as we continually reinterpret in the present.

I am not suggesting that we avoid making plans because we assume they will not work or are bound to go wrong during implementation; rather that we must acknowledge the important process of *particularising* – exploring and negotiating our meaning together, which will invariably draw out similarities and differences and be affected by our prejudices . The value of this process should not be lost in our desire to achieve the anticipated outcome.

Second argument: (i) Organisations do not recognise the significance of prejudice in processes of generalising/particularising. (ii) Prejudice can be considered as a manifestation of our expectations of meaning, linked to our own self-interests.

Making the connection between generalisations, expectation of meaning and rethinking our use of the word 'prejudice'

In the course of my research, I have sometimes expressed how influenced I was by working in the community, providing the kind of health care that was free of the constraints of working in a hospital and working with doctors. Community ways of working became my working ideology, on

which I based all decisions; before undertaking the DMan, I had not considered ideology as a constraint to my management practice. However, I now recognise the relevance of considering the ideologies that I and my colleagues subscribed to, because these clearly influenced the way we practised and the decisions we made.

Schein (2004) proposes that ideology articulates and illustrates overarching values that contain various myths and stories of heroism. This, he argues, can serve as 'a prescription for action in ambiguous situations' (ibid: 130). In my own experience, the idea of 'integrated care' was ambiguous, yet to some extent the strategic directives helped to establish an official story of what this meant for my organisation and a justified reason for creating it. Senge (1990) talks not of ideology, but of the notion that leaders can be influential in implementing strategies. He posits that strategies often fail to translate into action because our 'mental models' limit us to familiar ways of thinking and acting, and conflict with new insights (ibid: 163). I now find this view rather problematic, as it is difficult to reconcile with my own experience.

In Stacey's description, ideology is 'the tension between the obligatory restriction of norms, as social forms of control, and the voluntary compulsion of values, as a social motivator' (Stacey, 2012: 33) that can be important in understanding how our interactions with one another can provoke variation or repetition in our responses. For example, hospital ways

of working being better than community ways of working, or vice versa, could be seem as sustaining patterns of power relations, making one group feel superior to the other (Stacey, 2012: 30). Our interactions exist as dynamics of enabling and constraining relationships as we take the attitude of others in generalised or idealised ways. We are continually negotiating the evaluations of our actions in ways that we generalise as norms and idealise as values, which are then particularised in specific situations (ibid: 31).

In contrast, Gergen's (2009) constructionist perspective talks about our co-creation of 'new worlds' and calls for 'imaginary moments' in dialogue in which participants join in a reality not yet realised (ibid: 126). They move us towards a shared reality, suspending differences to locate a common purpose (ibid: 127). This was my intention in trying to get groups and teams to talk though their differences and to share in a joint vision. But I now question whether we can ever truly suspend our differences; to do so, I would have to assume that that I could escape from my own self-interests or my expectations.

Stacey views ideology as problematic, but his explanation focuses on the generative process of particularising. He describes ideology as 'imagined wholes' – constructs in which there is a tendency to idealise – and suggests that we immerse ourselves in imagined participation of them (Stacey 2012: 32). However, in describing organisations, he also

characterises these as ‘imaginative constructs around the patterns in interaction between human persons who can learn and be intelligent, or not, as social selves emerging in interaction’ (ibid: 60). In terms of ideology, aspects of value ‘arise in the course of self-formation through processes of idealizing key intense experiences and through the imaginative construction of the whole self to yield general and durable motivations for actions directed at what is judged to be good’ (ibid: 32). But when ideologies conflict, our generalisations must always be particularised in specific situations – because we have prior expectations, which arise from what we are familiar with (our prejudices) affecting how we particularise and make judgments.

My view is that our expectations of how we implement strategies or policies are affected by our own initial responses to social objects and our expectations of the experience in day-to-day conversations with others. This expectation, according to Mead, is difficult to detail in terms of behaviour (Mead, 1934: 86). However, I suggest that this expectation of meaning is my anticipated outcome, and my own self-interests encompassed in my prejudices, which Gadamer defines as ‘judgement that is rendered before all elements that determine a situation have been finally examined’ (Gadamer, 1975: 273).

Gadamer posits that we understand text on the basis of expectation of meaning drawn from our own prior relations to the subject-matter (ibid:

294). This perception of prejudice is helpful in discerning that meaning and understanding are productive activities (ibid: 296). What I take from Gadamer is that our prejudices denote our expectations of meaning based on what we know and are familiar with. In Gadamerian terms, how I interpret integrated care is governed by my expectations based on this imaginary picture I have of what it should look like. This is taken from my prior relation to the social object, which follows from the context of what has gone on before (ibid: 291).

Gadamer's premise for this way of thinking incorporates the hermeneutic rule of 'understanding the whole in terms of the detail and the detail in terms of the whole' (ibid: 291). Expectation of meaning changes in my attempts to interpret and reinterpret – the process Gadamer describes as the hermeneutic circle. He gives the example of learning to construct a sentence before we attempt to understand the linguistic meaning of the individual parts of the sentence (ibid: 291). But the process of construction is already governed by expectation of meaning that has gone before. I already had an idea of how I would implement the strategic directives; and I had already defined integrated care, based on my own expectations of meaning (my prejudices). But the strategic directives were continually changing, so my expectations also often changed.

My reinterpretation of the directives was unified around another expectation. So, according to Gadamer, the movement of understanding is

from the whole to the part, and back to the whole. In contrast, Mead describes not a whole but generalisations drawn from universals that have a paradoxical relationship to how we particularise. Our understanding emerges in our interactions. What I suggest is that meaning emerges from how we particularise generalisations, but at the same time we abstract whatever is general from our particularisations that can contribute to our iterations and revisions of strategic directives. For example, the patient at the stakeholders meeting enabled us to rethink our varying individual and group interpretations of integrated care. Our abstraction of his comment of being able to be seen in the right place at the right time would in some way change our original interpretations.

At the same time, our prejudices embody our expectations of meaning and self-interests, and this affects the ways in which we take up strategic directives and particularise them in contingent situations. What is important to note is that there is a temporality to our expectations of meaning: our prejudices will change over time. We will never achieve a definitive picture of the whole – a complete understanding – because our picture of the whole is continually forming while also being formed by our revised picture of the whole. But at some point, we come to some form of mutual understanding; until inevitably, in our interactions with others, another stimulus provokes challenges or disrupts our current understanding.

In the light of this, I'm left with a sense that our prejudices are emergent in our daily interactions, denoting our expectations of meaning in our anticipations of outcome and our self-interests, which are drawn from our experiences of working within a certain ideology – an ideology that we feel compelled to follow, because it has a general character that incorporates some form of moral good. This affects how we respond towards the strategic directives. Our prejudices do not suddenly arise from a vacuum, but through our experiences with others.

I have a history of experiences – both positive and negative – of integrated care, which clearly inform my expectations about integrated care in general. I have also been influenced over time by 'taking the attitude of others' – such as parents, social groups and professional bodies. My view of the world is prejudiced in that I am influenced by events, situations and ideologies that must inform any judgment, responding to my experiences of the past within the present situation I find myself. What emerges is a point of view, a preference, an expectation of meaning contained in my prejudices that provide a basis for my judgments. In this sense, prejudice is important to the process of understanding. Without it, we cannot know difference; and without awareness of difference, how can we make decisions?

A further reason why managers find it problematic particularising strategic directives into practice is that in consideration of strategic directives as generalisations, we do not recognise the significance of

prejudice in the process of particularising; we avoid recognising it because of the contemporary negative connotations of this term. In arguing to reclaim the term for this research, I am not using it in the pejorative sense, though I acknowledge its important associations with bigotry and discrimination. However, I would suggest that thinking of prejudice only as an aspect of behaviour, rather than as a social process emergent in our interactions with one another, restricts ways of thinking and problematises individual or group behaviour, implying a rigidity of self in relation to others that does not reflect my own experience.

In this section, I conclude that particularising strategic directives is a paradoxical process from which prejudice emerges – that is, our revised expectations of meaning, linked to our self-interest. Simultaneously, these expectations shape the way we interpret the directives, while at the same time being formed in the process of particularisation, which is an exploratory and negotiative process occurring in conversation. This enables us to see how the process of prejudice has the potential to be productive and generative to our understanding as it is continually clarified and reshaped in our ongoing interactions. I believe it is crucial to view prejudice as process of human relationships, rather than one of solely individual behaviour; this enables me to distinguish individual and social aspects, clarifying how transformation of ourselves and/or others in relation to each other might take place.

Theme 2: The individual in relation to the social

Third argument: (i) Prejudice is at the heart of resistance, which is a facet of human relationships. (ii) Managers cannot consider themselves outside of any relationship.

Opening remarks

This next section re-examines my understanding of the interdependence of the individual and social and its relation to resistance and prejudice. I will be reviewing Norbert Elias' thoughts on how we idealise the individual in order to understand how my thinking has changed with regard to middle managers being able to stand 'outside' any process in order to control and influence change. In our idealisation of the term 'middle managers', I argue that this problematises facets of organisational life such as resistance and prejudice by locating them with individuals. Instead, I will present a way of thinking about resistance and prejudice as facets that emerge from interaction as part of a wider social act.

Elias on idealising the individual

Throughout my early research, I have been clear that I considered my role of middle manager as one where I was in a position to control the processes of change. I described myself as an autonomous practitioner, which seemed important at the time as a way of distinguishing myself from others.
Relating this back to my understanding of my role as a middle manager, I

was conscious that all the leadership training I had received elevated this notion of autonomy and being objective. I saw myself as able to participate in stakeholder meetings, but also imagined that I could step outside the process and steer it through planned agendas towards pre-determined outcomes.

Elias criticises the tendency for human sciences to reduce sociological problems to biological ones, as though they are completely independent of one another (1978: 107). He posits that what distinguishes people from a set of biological processes is the changeability of human nature, which is demonstrated through history in the way societies have developed. His concern with the view of contemporary human sciences is that it is preoccupied with dealing with isolated objects in a fixed state (ibid: 115). In reflecting on my role as a middle manager, I come to the conclusion that I had an idealised view of myself as a manager. Thinking in this way enabled me to distinguish myself from others; and this is reflected in how I describe myself, which echoes my mental image of a traditional concept of autonomous individual – but, importantly, also enabled me to think of myself as distant from relationships to others.

> We end up believing and feeling we actually are what we ought to be and what we may even want to be. More precisely, we confuse fact with ideal, that which *is* with that which *ought* to be.

(Elias, 1978: 118)

Elias makes the point that this idealised way of thinking about the individual can lead people to believe that they are somehow separate from the outside world. Taking Elias' perspective, distancing myself from others is a reification of a socially indoctrinated detachment acquired through my training and education of my own self- experience (ibid: 122). One of the ways I notice that I have articulated this in my research is to make reference to the third person, such as 'the executive managers' or 'middle managers' – distancing myself from association with their functions, and overlooking the fact that these terms designate many people who make up the organisation and with whom I have some relationship. What I surmise is that in reifying, we simplify the functions of managers, reducing relationships to a single perspective which, according to Elias, hides the true nature of events (ibid: 126). Focusing on individuals, rather than on the interrelationship of the individual to the social, fails to reflect the complexity of what happens in organisations in our day-to-day interactions and obscures the Eliasian concept I find so helpful, namely that the individual is the singular and the social is the plural of our interdependence on each other.

The importance of relationships in our day-to-day interactions

Elias (1991) focused on the process of individualising, which he also describes as a social process. In my reflections, I can see a pattern of

attempting to define myself by pointing to my relationships with various people. For example, in my projects I describe myself as a friend, manager, subordinate, and colleague. But could I have really defined myself thus in the absence of others, or chosen one above any other? In his book *The Society of Individuals* (1991), Elias argued that all self-definition rests on the individual referring to other people in their mutual recognition: there will be something recognisable or universal in our behaviours towards one another – such as shaking hands associated with greeting; crying associated with distress, but also with happiness. From an individual perspective, in order to be part of society we take on these aspects of that society. Elias' thinking was that society shapes the individuality of its members, and that individuals form society through their everyday interactions.

This view contrasts with authors such as Senge (1990) and Schein (1994), who are renowned for their ideas on developing individual leaders armed with an array of learnt skills that set them apart from other groups and enable them to influence change. Schein idealises leadership in terms of autonomous individuals who can shape the organisation through the ways that they participate with others. Senge, on the other hand, idealises learning through learning organisation theory. Participation of the individual with the right skill can influence the process of change. This becomes problematic because organisational resistance and conflict are viewed as undesirable, and therefore treated as problems to be solved through the intervention of

the individual. This seems to oversimplify human experience of interaction: in striving to avoid negativity, this approach fails to acknowledge the importance of conflict and difference, and elevates control to a handful of powerful individuals. Elias points out that 'the primary function of the term "individual" was to express an idea that every human being in the world is or should be an autonomous entity, and at the same time that each human being is in certain respects different from all others' (Elias, 1991: 156). For Elias, individualisation is an activity that is re-enacted in daily interactions; but what I also come to understand is that it is a process of exploring similarity and difference in relation to others.

In drawing on similarities in organisations, parallels can be drawn with the activities of individualising through the development of managers and in the formation of structure. At the same time, the particularising activities of managers happen in the daily ongoing explorations and renegotiation of mutual engagement. Nevertheless, the processes of individualising are not static; they change over time through successive conversations, so that the individual can only be understood in relation to the social and vice versa, both being fluid. I can see that my understanding of who I was as an individual at the start of my research is not the same as it is now: I lacked insight into the importance of relationships. Early in my research, I struggled with the idea of managers not being in control. I felt I was still trying to locate a question based on my role as a middle manager,

as if there were something particular that set myself apart from others. I considered myself as an individual, above any social phenomena – in a sense, oblivious to the paradoxical interplay of individual and social.

Elias has enabled me to understand that the individual does not take priority over the social, nor vice versa, and that our relationships are interdependent. I also realise now that idealising the individual – reducing the notion of management to a single perspective – concealed facets of relating such as prejudice, as well as problematising other aspects such as resistance to change; rather than recognising the individual and the social as phenomena that are continually emergent from our relating to one another. This has implications for practice, in that in organisations we tend to place emphasis on the development of leaders and managers, as though the success of any change depends on how competent and capable they are. Of course, these qualities are important; but they change over time and in relation to others. We pay little attention to how understanding emerges from interactions between people, and that this continually changes in both productive and unproductive ways.

Knowing what I do now, I would not have been so quick to assume that agendas and plans would enable me to control conversations or reduce or manage conflict. While these approaches sometimes may be helpful to organisational management, it may at other times be equally useful to explore difficult relations with others, focusing in detail on the interactions

and keeping conversations open, thus allowing for new meaning and new understandings to be generated.

This is by no means to suggest that conflict should be provoked for its own sake; simply that when it emerges we could embrace what we can learn from it, rather than avoiding it at all costs. Practising within the confines of learning organisational theory, I was aware of the need to avoid or reduce conflict where possible; I was of the belief that I could somehow control and avoid any variation in conversation that might provoke arguments or reveal differences. Senge, for example, advocates how a manager should develop and practice through personal mastery, suggesting that managers are in positions to manage conflict (1990: 147). However, this no longer resonates with me now that I understand that conflict, as well as resistance, is inevitable in our relating to one another. More importantly, when conflict arises we have the potential to challenge ways of thinking – including our own; and I now understand that the way in which I and others participate offers the opportunity to create new meaning through the process of exploring and negotiating in conversation and holding onto the tensions and paradoxes that arise.

Reducing relationship to an individual perspective problematises resistance

In considering myself as an autonomous individual, I was surprised at how easy it was to assume a detached way of thinking and to ignore aspects of relating that were inevitable to any processes of change. Looking back on

my initial considerations of how I, as a manager, viewed resistance to change, I wrote at the time that that this resulted from holding on to our identities when we believed them to be under threat, and began to understand that this was an inevitable human response when confronted with change. The theory of complex responsive processes understands organisational life as the emergence of population-wide patterns arising from the interplay of intentions in our local interactions (Stacey, 2012). For me, this signifies that consideration of resistance from an individual perspective encourages us to think unilaterally about resistance: it becomes easy to think of it as a problem located with the individual that can be resolved or controlled by a manager. This is where traditional management discourse fails to appreciate the multifaceted nature of resistance – indeed, Elias would say that the approach 'hides the true nature of events' (Elias, 1978: 126).

In my reassessment of resistance, I reflect on the perception of myself as a manager in relation to others and my role in managing and controlling. It now becomes apparent that power relationships are not in themselves forms of repression and/or oppression, as I had originally assumed. To characterise the process of particularising from an individual perspective encourages a static way of thinking about power relationships. This holds them in a state of inequity, so that as a manager, thinking of myself as being able to stand outside the process of change – that this was

something ‘I’ was doing to others, or ‘they’ were doing to me – I would always believe myself to be the person either in control or subjugated; but having this singular perspective obscures the fluid and temporal nature of the relationship. Elias describes relationships between human beings and their functional interdependencies as processes, using the term ‘interweaving’ to point to the processual nature of such relationships (Elias, 1998: 120). His view is that power is intrinsic in all human relations, and that it is the power differentials that influence situations.

In their particularisations of strategic directives, managers affirm this location of control – what Scott (1990) refers to as the ‘public transcript’, which he defines as the official story. At the same time, using Mead’s analogy of communicative interaction (Mead, 1934), particularising may invoke a response of resistance or provoke ‘hidden transcripts’. Scott describes such expressions as rumour, gossip, euphemism and concealment. These forms of resistance require little coordination and planning, but signal the relational aspect of interaction between myself and subordinates. Power relations arising from how we are particularising are enacted on the basis of strong affiliation to a particular ideology that shapes our way of thinking. The content of many management training programmes tends to reinforce hierarchical ways of thinking about managers and their staff, presenting the relationship as static (e.g. the manager will always have subordinates, or staff will always be dominated by managers).

This brings me back to the point that Elias (1991) makes in his book *The Society of Individuals*, and another reason why I cannot think of myself as separate from any form of relationship with others. Elias argues that we are all in some way interdependent; even seemingly unconnected people in organisations 'are tied by invisible chains to other people' (ibid: 14) – for example, I could be linked to others through my managerial role, or in my professional role. Individuals could also be linked by policies and procedures or by the ways in which they practise. In my description of self, all the relationships I have with others are interdependent functions (ibid: 16). This means that our actions with others, numerous as they may be, 'must incessantly link together to form long chains of action if the actions of each individual are to fulfil their purpose' (ibid: 16). These long chains bind us together, and are elastic and interchangeable. Elias is suggesting that although we are linked in our relationships, this relationship – which he describes as society – is both enabling and constraining at the same time; he presents interwoven interdependencies as a way that we as society self-regulate our actions and further shape them in our relations with each other (ibid: 37).

I have already noted that I had an idealised view of myself as a manager that enabled me to distinguish myself from others, and this is reflected in how I described myself as an autonomous individual. More importantly, it made it possible for me to think of myself as distant from

relationships to others and reducing relationships to a single perspective, which obscured the true nature of relating to one another. In this section, I surmise that the individual does not take priority over the social, and vice versa; and that reducing facets of organisational life – such as resistance to static negative behaviour – becomes problematic only when we assign responsibility for them to particular individuals. From a social perspective, these facets can be recognised as a necessary process in the ongoing formation of our understanding.

Theme 3: Prejudice – a process of understanding

Opening remarks

In this section, I reappraise our understanding of prejudice in relation to the individual and the social, and argue that prejudice is not inseparable from either. In considering another way of thinking about prejudice, I draw on the views of Hans Gadamer to explore the notion of prejudice as a process of understanding that contains our expectations of meaning and our own self-interests. Thinking about prejudice in a broader context, rather than focusing on individual behaviour, presents further possibilities in transforming our thinking.

Prejudice is inseparable from the individual and the social

When I came to writing Project 4, my thoughts and actions as a manager were dominated by my affiliation with community- rather than hospital-

based health care. This prejudiced my interpretation of integrated care, in the sense that I was biased against hospital working and, in particular, biased against doctors. This individualistic way of thinking made it difficult for me to appreciate how others were also particularising integrated care in their own terms – bringing their own self-interests into play and having their own expectations of the meaning of the organisational strategic directives. For Gadamer, prejudice considered in terms of process offers a way of acknowledging our subjectivity, which he felt was important in our understanding of the self. It became evident to me in Project 4 that my partiality towards community working was influencing my thought processes; as soon as I realised this, I felt it would have been unreasonable to ignore how it influenced my decision-making and my judgments.

So from a management perspective, how did we become prejudiced against the term 'prejudice'? The answer lies in the research on prejudice carried out over the past century, which closely reflected the ideological trends, indicating much about the personal biases of the scientific community (Plous, 2003). Plous states that sociological and psychological research reflected the emergence of race theories, which became prevalent in the early 1900s. The proliferation of research focusing on prejudice and its association with difference, race, culture and discrimination has to a large extent coloured our views and perceptions of the use of this term. Plous identified that over the years, an aggressively reductionist approach to

prejudice enabled the establishment of laws, regulations and social norms mandating fair treatment, shaping a negative contemporary understanding that associates personal bias with acts of bigotry and discrimination.

In reflecting on Elias, I can now understand how we come to oversimplify aspects of individuals' behaviour as if they are something fixed and static:

> So individuals may justifiably be seen as a self-transforming person who, as it is sometime it, goes through a process – a turn of phrase akin to 'the river flows' and the 'wind blows'. Although it runs counter to our usual habits of speech and thought, it would be much more appropriate to say that a person is constantly in movement; he not only goes through a process, he is a process.
>
> (Elias, 1978:118)

This is by no means to suggest that the pejorative use of the word 'prejudice' has no place in organisations: there are clearly times when it is appropriate when considering the subjective nature of behaviour. However, I believe that Gadamer's broader view of prejudice as a process to understanding offers a useful concept in the wider context of organisational life. I would question his use of the term *condition,* which for me implies causality and still could be viewed as a reductionist term even though Gadamer's intention was to signal a prerequisite to the process of

understanding. Perhaps Elias' reference to the *process* of human relationship is a more helpful term in appreciating how prejudice can be viewed as potentially generating new meaning and understanding grounded in the relationship itself.

Taking a complex responsive processes perspective, I have moved away from thinking in terms of a dualism – seeing individual prejudice as undesirable, but social prejudice as a potentially useful process. Given Elias' perspective that the individual and social are inseparable (Elias, 1978: 129), I now consider prejudice in relation to both the individual and the social, referring to two independent but *inseparable* 'horizons' of organisational life that require us to take seriously our prejudices in considering organisational change.

Taking our prejudices seriously

Having established that there are positive ways of viewing prejudice, I turn to consider how this might be applicable in our day-to-day interactions with others. If we think of particularisation as an exploratory and negotiative process, in Gadamerian terms, our 'horizons' shift throughout the course of this research, as we are involved in coming to an understanding with ourselves and with others about how we are interpreting generalisations or idealisations such as 'integrated care'. In linking this back to the social object, this then invites a review of our notion of implementation – not as a pre-determined, self-evident plan that can be 'rolled out' unproblematically,

but as a gesture that will evoke both predictable and unpredictable responses, which may transform or perpetuate existing social objects as we confront our prejudices in making particular a generalisation in which both context and time is important.

What Gadamer terms a ‘fusion of horizons’ is where we explore possible meanings together until we reach a consensus, or a workable shared meaning, at a particular moment in time. This fusion is dependent on how we particularise the social object in our everyday interactions. Through conversation we gesture and respond, drawing on our history and traditions which are themselves changing through our successive reinterpretations. After years of working in particular ways in the community, I cannot easily discard the prejudice I have around medical-led models; this has come to form part of my history and tradition. How then do I as a manager begin to take my prejudices seriously?

Gadamer makes the link between reason and tradition by arguing that understanding is not just about interpretation (how we make sense of something) but also about application (how we apply this sense-making to the context of our everyday experiences); this will always be affected by our past experience, which we call forth and utilise in the present. So I will always bring my past experiences into any decision and judgments I make in the current context. Even though I am sympathetic towards community ways of working, I have to continually challenge my ways of thinking,

without assuming that we will arrive at a pre-determined destination or that that we achieve a complete story. The journey to understanding perpetually moves us into the known and unknown, familiar and unfamiliar, predictable and unpredictable. I now understand that 'integrated care' is an evolution of our particularisation of the term, which is forming our understanding while at the same time being formed from our understanding.

I need to be aware of how the inadequacy of my interpretations distort and obscure the way in which I particularise generalisations and idealisations in bringing my inherited prejudices into play, which means exposing or acknowledging them in certain situations in myself and in others. However, I know that my prejudices can also enable and/or constrain the extent to which they enable me to confront them. However, the application of this understanding demands some practical judgement and also requires managers to be able to hold on to the tension of contradictory situations. I now acknowledge that I cannot rid myself of my prejudices, which are an inherent part of my historical identity; but in a social context, I may revise them by achieving a level of self-awareness or reflexivity in paying attention to subjectivity in which that Gadamer refers to as 'effective-historical consciousness' (Gadamer, 1975: xvi). This requires me to be continually aware of what this effective history is that is sustaining my prejudice and shaping my understanding of my own situations, both past and present, as well as my anticipation of the future.

From a complex responsive processes perspective, recognising that the individual and social are inseparable, I realise that self-reflection can only take place in relation to others, as evidenced by the interactions I have described throughout my narratives. Is it practical, then, to bring my prejudices – my inadequacy of inherited understanding – into open confrontation, or to draw attention to the prejudices of others where I notice them? This could be both creative and destructive at times; perhaps the manager's skill is in sensing when to take that risk.

Accepting prejudice as a process to understanding, which denotes expectation of meaning as well as our own self-interests, opens up possibilities for transforming ourselves and prioritises the significance of our relationships with one another in transformation. What I draw attention to is the potentially generative and productive nature of prejudice if we think about it as an inevitable process in the development of mutual understanding. I would suggest that managers should continue to question and challenge not just others, but also their own attitudes that they assume to be universal. If our own prejudices are tested by what another person is saying, it is unproductive to just ignore them or setting them aside in blind adherence to directives or because we do not want to confront the unsavoury. This is not to urge managers to continually take risks by perpetually pursuing confrontation; this would result in intolerable levels of anxiety and conflict, and may even put their job at risk. But what I have

discovered in my research has given me the insight, and a little more courage, to take more risks and use practical judgment in exploring some of the prejudices inherent in my interactions with others.

I have concluded that risking bringing our prejudices into play may provide the opportunity to begin to navigate a path towards new understanding – mindful that there is no guarantee that such an understanding will be judged as better or worse than what went before. I would therefore propose that it is more helpful to understand the work of a middle manager as that of skilfully engaging in this dialectical emergent process of conversation, rather than following the assumption that pre-determined outcomes can be achieved through the application of blueprints and models.

In transforming ourselves and our organisations, we must be able to practise reflexivity by becoming aware of our prejudices, assessing when to take the risk of bringing them into play, and keeping an open conversation that enables spontaneity and creativity in which we can sometimes challenge and revise ways of thinking. In this way we can use interactions to explore and negotiate our differences and similarities, our limitations and inadequacies of understanding, and open the possibilities for transforming our horizons.

Part 3: Understanding the research method

Methodology

Reflecting on complex responsive processes

Qualitative research

Throughout my career, I have been heavily influenced by empiricism and evidence; but the process of becoming more aware of prejudices requires me to pay attention to my own experiences, which will inevitably be subjective. 'The complex responsive way of understanding organisational life in organisations has implications for appropriate methods of research in management and leadership' (Stacey, 2011: 487). This way of understanding leads to a more generative kind of questioning that enables participants to challenge their assumptions, prejudices and practice. It is an ontological process of self-reflection and self-reflexivity. This synopsis, which explores my most recent reflection on my reflections, is a good example of being able to think about and explore my prejudices, which become exposed when I encounter diverse and different ways of understanding. I am encouraged me to think about how I am thinking.

Qualitative research represents a diverse set of techniques and philosophies that underpin research practice in the human sciences (Silverman, 1994; Mason, 1996; Maggs-Rapport, 2000). A qualitative approach is one of exploring human behaviour and the search for

understanding in people's actions and experiences. In contrast, evidence-based medicine has been described as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of patients' (Sackett & Rosenberg 1996).

Criticism of evidence-based medicine within the NHS is that it has now been used to the exclusion of any other forms of knowledge acquisition (Cohen et al, 2003; McKenna et al, 1999). The problem is that it elevates experimental evidence and assumes that scientific observation could be made independent of the theories, bias and prejudices of the observer/researcher. The scientific rationale demands evidence that is publicly verifiable and can be measured objectively, yielding data that can be replicated by multiple observations (McKenna et al, 1999). This approach also assumes linear causality: if you do *A* and *B*, then you get the outcome *C* – which, of course, did not happen in my narratives. A further argument against evidence-based medicine is that it imposes methodological limits that constrain practice (Misak, 2009). Misak argues that our efforts to eliminate subjectivity and individual judgment do not allow us to broaden the range of evidence employed. Within the context of this project, then, a contradiction emerges regarding evidence-based practice and the value of everyday experience that is organisation; because experience is subjective. In the context of complex responsive processes, experience is dependent on relational activity – forming and being formed in our interactions with each

other. This generates responses that are governed by our emotions and our tendencies to act, and how we view and construct and make sense of the world around us.

Narrative as a method

The method of narrative, in complex responsive processes of relating, is one of the ways in which we can make sense of our own experience. Bruner (1986) proposes that humans make meaning and think in terms of 'storied text' which captures the human condition, human intentionality, the vividness of human experience very fully (1986: 14–19). Narratives become the data from which we analyse through interpretation; thus, subjectivity becomes the premise for understanding. By understanding organisational life from this perspective, the focus is on participation in many local interactions (Stacey, 2011: 488). Stacey asserts that 'experience is the experience of local interactions'; that the research itself can be considered as complex responsive processes; and that the research method is a reflection of ordinary everyday experience (ibid: 488). Misak understands that narrative can provide further evidence of experience; for example, patient experience can be high quality if we subject it to the full range of critical practices – but Misak's insistence on the use of objective evaluative criteria presupposes that there is an absolute truth to be identified from narrative, and judgment that must be applied.

From a complex responsive processes viewpoint, the use of narrative is not a quest for a universal or scientific truth, but more a quest for meaning. In his book *Sensemaking in Organisations* (1995), Weick is clear that 'making sense' is not about accuracy; it is about plausibility, pragmatics, coherence, reasonableness, creation, invention and instrumentality (Weick, 1995: 61). 'Narrative as a research method is reflexive in an individual sense insofar as the narrator is making explicit the way of thinking that he or she is reflecting in the construction of the story' (Stacey, 2011: 488). What Stacey means by this is that we are in the midst of living and telling, relieving and retelling the stories of experience that make up our lives. My narratives have enabled me to reflect upon critical incidents (events that do not fit our customary worldview). Reflection allows me to discover, unintentionally, that patterns of behaviour (themes that arise) become triggers for questioning my predominantly prejudiced and subjective understanding. In challenging my reflections based on my understanding at the time, I notice how inadequate my previous interpretations or meaning have been, and at the same time seek to revise these interpretations or meaning. This then forms my new understanding, which again will be subject to challenge and reflection.

Group meetings as a method

One of the main difficulties I experienced at the beginning of my research was the intention behind the community meetings at the residential

weekends. These took the form of sitting in a circle and waiting for a participant to bring in a topic of conversation or an observation; the group would then discuss any issues raised (or at least, that was my initial interpretation of events). My foremost expectations were that as individuals, we would discuss a problem, just as everyone in the group would also take part in the discussion around a problem. Very early on, I found it difficult to participate in this activity, which had no sense of purpose or outcome for me; but slowly, through successive residentials, I began to participate in the conversation simply as a way of taking part. I found myself moved to speak and drawn in by the content of the conversation and the content of the discussions. But I was not paying attention to how I was participating, or reflecting on the interactions between others and myself.

What I have come to understand is that by having an awareness of what we are discussing and how we are discussing it, I can in some way begin to articulate the experience of the interaction. It occurs to me now that this activity draws out the relationships of individual to social. In a sense, the group meeting has enabled me to be reflexive and to pay attention to actions that we otherwise take for granted in everyday conversation when taken from our individual perspective alone – such as avoiding conflict; trying to control or influence conversations by setting boundaries or ground rules; ruling out any undesirable behaviour. All these strategies tend to stifle spontaneity and creativity.

Experience, when conceived in a dialectic conversation, can stimulate situations of conflict. This has happened in the group when a disagreement arises between participants. What emerges from the conflict is a disruption of our understanding of ourselves and the world in which we interact, but at the same time, the group situation that we find ourselves in. Our willingness to engage in continual exploration of our behaviour allows us to revise our understanding and serves to create new meaning.

The theory of complex responsive processes seems to offer a way of responding to a view of the world that no longer fits with customary expectations of how a manager should act. In our group discussions, we cannot respond to our differences and similarities while also distancing ourselves by seeking objectivity and control. We are all actively participating in the developments of understanding from the perspective of the individual in relation to the social, and vice versa. By paying attention to how we as participants relate to one another, we can begin to take seriously our experience of what is happening at that moment. This invites us to revise the ways in which we understand the past and anticipate the future. This is where it is important to note that self-understanding in this group process is not one of individualisation, but one that considers the temporality of our world, which means the day-to-day interactions that I have with others. This requires us to experience not just the content of the

conversation, but also the interaction itself, locating our interactions in relation to others.

I am not proposing this approach as a technique, or suggesting that somehow problems will be resolved if we all sit down and talk in a group; simply that this social environment offers us an opportunity to experience challenging and taking risks, keeping the conversations open. It is another way of accessing phenomena by paying attention to our experience and observing and reflecting on patterns of behaviour as they arise. In our ongoing conversations with one another, which on many occasions have been challenging or questioning, our responses (our sense of curiosity) enable us to recognise subtle details that we might otherwise have overlooked. This opening up to critical experience moves the group participants to bring into question our subjective understanding, which is often manifested in a range of emotions. This disruption of our individual or collective prejudices of the world moves us to self-understanding through the group actively engaging each other in ongoing conversation, as part of a genuine desire to explore the unknown.

Reflexivity – hermeneutic approach and self-reflective awareness

Reflexivity is traditionally associated with social scientific research, where it is important to recognise the influence on self. We might think of managers as a social object; but my experiences are subjective – in this sense, I could be considered as the ‘object’ and my experience as the

‘subject’ in the reflexive process. It has been described in a number of ways by various authors such as Stacey, who views reflexivity as ‘the ability to look inwards and outwards to recognise the connection with social and cultural understanding’ (2010: 10). Alvesson and Sköldberg (2009) describe this as the researcher and object mutually affecting each other continually through the research process of common context, so that they are thus context dependent (ibid: 79). Fook and Gardner have a broader definition (2007: 27), which involves the ability to recognise all aspects of ourselves – including the physical. Even within these definitions, there are varieties of reflexivity where the researcher is part of a particular social field in order to understand specific relationships with regard to particular situation that might give rise to patterns of action (Alvesson & Sköldberg, 2009: 8).

Within the context of my research, reflexivity enables me to examine my actions as a middle manager within a particular situation of organisational change, responding to strategic directives; and the competing priorities that create patterns of actions among organisational members under the condition of power dynamics, leading to inclusion and exclusion. Reflexivity is therefore important because it enables us to make sense of organisations through experience, which will include emotional aspects of inter-relating. Cunliffe (2004) finds it useful to apply critical reflexivity to management education, because it offers a way of examining the assumptions of current management practices; and in doing so, we can

uncover their limitations and possibilities. Calas and Smircich (1992: 240) speak of reflexivity that constantly assesses the relationship between 'knowledge' and 'the ways of doing knowledge'. Alvesson and Sköldberg take an interest in the ways in which linguistic, social, political and theoretical elements are woven into knowledge development (2009: 9).

Thus, to define my research as the creation of knowledge would not separate it from daily experience. However, while I understand how these authors define reflexivity, I am also aware that the perspective they take is one that locates knowledge acquisition firmly with the researcher. This is in contrast to my argument, which takes on Mead's views of meaning arising in the social process of gesture and response (Mead, 1934). Knowledge acquisition in the context of this research emerges from the interaction between myself, the researcher/object, and my experience, the subject of my research.

The hermeneutic approach that Gadamer subscribes to holds more relevance for me as the researcher, in terms of reflexivity and in thinking about complex responsive processes. Unlike scientific approaches, which seek to neutralise or eliminate the activity of the researcher, hermeneutic approaches acknowledge the mutually transforming involvement of the researcher with the object known. Holroyd (2007) argues that what is taken seriously is the understanding of what meaning the object takes on for someone within a particular context of experience. Hermeneutic

understanding emerges from our encounters with the object or between the selves in relation to others. Therefore, involvement with one another is essential to understanding.

Hermeneutics, within a philosophical context, links understanding to existential meaning (Alvesson & Sköldberg, 2009: 120); being in the world can be grasped as a direct and unmediated condition of authenticity and subjectivity. Gadamer claims a universality of hermeneutics in that no form of knowledge can escape the limits of interpretation, which are bound to our traditions embedded in history (Gadamer, 1975). Language is pivotal in this, because it shapes all the situations and experiences in which we find ourselves (Holroyd, 2007).

How does this experience relate to me as a manager interpreting strategic directives on integrated care? I think the possibility to draw on a hermeneutic understanding arises when I experience conflictual situations that disrupt the 'taken-for-granted' aspects of my management practice. Holroyd suggests that as human beings, we are motivated to create meaning in the different experiences that shape our lives. Hence, we reflect upon the context of our dominant ideologies and common practices of understanding within our epistemological framework. Although my practice had been heavily influenced by traditional ways of working within NHS organisations, I have now become aware that there have been limitations in my thinking, which at the start my research existed in a scientifically

dominated perspective that was evidence-based and empirically driven. This resulted in a tendency to reduce human experience to a *problem*, which as a manager I was expected to fix. So I could very easily have identified in Project 2, the 'problem with communication'; in Project 3, the 'problem with resistance to change'; and in Project 4, the 'problem with prejudice'.

What I have come to understand of hermeneutics as an approach in relation to complex responsive processes is that experience is taken seriously, with no intention to reduce this but rather to recognise that these project themes are meaningful and complex. To better understand these themes requires me to reflect on myself in relation to others with a view to making sense of my actions and interactions in day-to-day organisational life. Our behaviours do not correspond to the behaviour that is ascribed to managers in traditional management practices, governed by organisational norms. It is through our experiences that we come to recognise how our history and tradition encourages a particular way of thinking, which in turn limits our ability to understand that which we do not yet know.

Validity and generalisability

In taking my experiences seriously, I would not wish to yield to bias and allow my opinions and views to influence the research unduly; but it is precisely the subjectivity of my thinking that is the focus of my research. I am seeking to validate my personal experiences, which could be criticised for lacking generalisability. Koch's (1998) answer to this is that credibility

comes in presenting ‘faithful description’ in whatever we are studying. As the researcher, I must demonstrate how I have arrived at a particular interpretation in such a way that it becomes meaningful to others. In the narratives I present, I am observing differences and similarities in patterns of behaviour. I should be able to show how I arrived at a particular view, supported by theoretical, methodological and analytical choices. Koch (1998) also argues for reflexivity, which acknowledges that interpretation exists in a complex matrix of alternative representation (ibid: 1188). Insights drawn from reflexive awareness can provide validity and rigour in such a study.

For me, validity is also tested by whether what I have written is acceptable and plausible among my peers. I have written about things that would be highly sensitive to my colleagues in the workplace; to that end, I have anonymised individuals and the names of the organisations involved. I have also identified key individuals who I have written about and asked them to peer review my work, ensuring that my narratives remain authentic even though they may not be taken up in the same way. My work has been reviewed and iterated by fellow students on the DMan programme, as well as by a variety of supervisors. This exposure ensures that in my understanding there is accountability for what I have written through successive challenge and revision, so that new meaning emerges.

My representations come from my interpretations of critical events, which I record as part of my narrative and in my experiences in group meetings and learning set. These provide me with a context for my judgments, while also allowing me to recognise the history that links past to present expectations as my thinking changes through the process of research. What becomes generalisable is whatever is recognised and familiar to another reader when decontextualised. I have signalled the reader by identifying particular themes that are common patterns of action, experienced in organisation, in the hope that they resonate with other people who will see their relevance to their own situations when taken up in other ways.

Part 4: Contribution to knowledge and practice

What is 'generalisable'?

It appears that in an unstable environment such as the NHS, problematic situations continue to arise in organisations despite our attempts to stabilise through policies, procedures, directives and strategies. I have sought to demonstrate that these are not a set of fixed instructions that can be translated directly into practice. They have emerged from our experience of immersing, abstracting, participating and reflecting in local interactions and are articulated as a set of rules or instructions; and our responses to them may change, depending on the way that we particularise them – which, I

conclude, is a process of exploration and negotiation and a part of human interaction that is a social phenomenon. This cannot be predicted or planned for, given the range of self-interests calling forth different responses, each contributing to the ways in which we particularise; at the same time, any meaning that arises will be forming, and simultaneously being formed by, each successive iteration in the present. So, with the passing of time, our understanding and interpretation of the directives will change.

I believe that in organisations we need to reconsider how we view and develop managers whose day-to-day work is to implement instructions. We cannot continue to think of managers as autonomous individuals who can objectively stand 'outside' the process of change, because this reduces and problematises facets of organisational life that are inevitabilities of our interactions with others. This has implications for how we should be developing our managers and leaders. It is perhaps time for the NHS to move away from considering management practices as individual phenomena and begin to acknowledge them as social phenomena, recognising the interdependencies of our relationships with one another – no matter how distant we may feel from the structures and hierarchies we have developed.

Contribution to knowledge

I have identified prejudice as an important new aspect of complex responsive processes, and have thus contributed to the theory by recognising

its significance in the process of understanding. However, I suggest that in current organisational management discourse we fail to notice its relevance, as we prefer to dissociate ourselves from its negative connotations. Thinking about prejudice merely as a characteristic of individuals restricts thinking in ways that problematise understanding individual or group behaviour as separate or distinct, or at different 'levels' rather than the singular and plural of the phenomenon of interdependence. It sustains the illusion of the unchanging nature of self in relation to others.

In reclaiming the term 'prejudice', I find Gadamer's (1975) definition more productive to our understanding. I suggest that prejudice can also be considered a manifestation of our expectations of meaning, linked to our own self-interests. In my research, this affects how we particularise strategic directives and at the same time generalise how we make particular those directives. The view of the world that we have (which I liken to Stacey's description of organisations as an 'imaginative construct' [Stacey, 2012: 60]) is seemingly perpetuated by the ideologies we follow – as reflected in the decisions, choices and judgments we make. Nevertheless, these very ideologies are continually changing over time, as we are provoked into responding to situations arising from conversations that challenge and question our worldview.

As our prejudices are iterated, so they are simultaneously, through the dialectical movement of conversations, forming new expectations of

meaning. This way of thinking allows us to see the transient and changing nature of our worldview, of strategic directives, of ideology and of ourselves. I further suggest that if we accept prejudice as a process to understanding, this potentially opens up possibilities for transforming ourselves.

Contribution to practice

I suggest that it is not possible to predetermine an outcome and that in traditional management practice, locating change with individual managers obscures our capacity to understand the processes of organisational change in the much wider context of social phenomena. I therefore conclude that my original and significant contribution to the theory of complex responsive processes and to the practice of organisational change is that encouraging a different way of thinking about prejudice as a process can be productive and generative to our understanding if we consider this to encompass our expectations of meaning, linked to our own self-interests. The implications for management discourse are far-reaching, in that this represents a shift away from the idea of resistance to what are fundamentally our prejudices, which can be revised, in communicative interaction. Remaining open to the meaning of the 'other' means that we allow ourselves to learn constantly from our interactions. Being aware of our own prejudices is important: this enables us to constantly revise our current interpretations, eventually acquiring a much more nuanced appreciation of 'otherness'. This opens up

the possibilities of transforming ourselves in relation to others – and, through this process, to transform our organisations.

However, I recognise that it is not feasible or practical to relinquish traditional discourse in favour of complex responsive processes. I cannot readily abandon the familiar practices and traditions that have influenced my ways of working. The dominant management theories that idealise approaches and leaders continue to flourish in the NHS, particularly as reform and change have become endemic. However, our tendency to assume that this is the only way to approach change is misleading. Managers need to be alert to the ways in which traditional theories can marginalise or gloss over difference – ignoring or problematising its existence, while at the same time asserting a singular perspective that limits our ability to explore differences with one another.

My new familiarity with the theory of complex responsive processes has led me to believe that for new meaning and understanding to emerge, managers must be more responsive to social phenomena. In paying attention to what emerges from our interactions, managers could be more able to skilfully engage with others, using practical judgment and experience to take risks and to challenge and be challenged.

It may be helpful to accept a broader definition of 'prejudice' in the NHS if we are to gain a wider understanding of change, given that its contribution to management discourse is significant in our exploration of

difference and similarities in the workplace. More importantly, this would enable us to observe the changing nature of prejudice itself, as well as the more nuanced understandings that can be derived from it. The NHS needs to consider the extent to which its current ways of working potentially enslave ways of thinking, which can become problematic when people go through large-scale integration.

I suggest that transformation of self in relation to others can only happen if we demonstrate our intention to take risks, putting our prejudices into play, daring to engage in potentially more meaningful interactions. It is equally important for managers to develop a sense of spontaneity and creativity, which requires us to hold the tension of paradoxes rather than to try and resolve situations that are not resolvable and can result in dilemma. The emergence of new meaning requires us to pursue our curiosity and that of others in conversation, allowing us to consciously and unconsciously explore and negotiate our prejudices, our limitations and our inadequacies of understanding – all of which can offer possibilities for change. Of course, we cannot know whether this change will always be for the better; only that what arises is likely to be different from what went before. In managing such situations without assuming we can control them, NHS managers need to be able to practically judge situations by establishing reflexivity in practice.

Underpinning my research is the inseparability of the individual and the social which must be understood as social phenomena. They coexist in a paradoxical relationship, emergent, transient and evolving in all interaction. To paraphrase Hazlitt, in my opening quote, I suggest that without the aid of reflexivity to draw attention to our relationships, intentions and interdependencies with each other, as well as to 'our prejudices and customs', how can we 'find our way across a room' – that is, find our way to meaning and shared understanding?

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