

Faith in the 'cultural fix': limits to a planned cultural change program in a rural health service

KERRY MAHONY.

Kerry Mahony is a PhD candidate in the Faculty of Humanities and Social Sciences, University of Technology, Sydney

Abstract

This paper, by way of a narrative on the author's participation, explains the limits to a planned cultural change program in a large rural health service. Cultural change was identified by the CEO as crucial to the success of a major restructuring of the service, and the attitudes and beliefs of the 'old guard' were considered to be constraining progress. Advocates of cultural integration contend that shared core values across an organisation can overcome such obstacles. This is a matter of faith. An application of Habermasian theory suggests that organisational leaders are drawing on traditional/religious beliefs and practices to bolster their visions and missions at a time of motivational crisis.

Though a need for cultural change in some sectors of the health services is acknowledged, the particular challenges in attempting to manipulate the traditionally embedded culture and sub-cultures of the health services is highlighted. An analysis of some of the ideas and beliefs surrounding authority, deference and discipline is undertaken. It is argued that the ritualistic reinforcement of these beliefs and the reproduction of sub-cultures along material and ideal interests militate against the implementation of objectives delineated by the CEO.

While cultural analysis has revealed the irrational face of organisations and can bring to conscious awareness the taken-for-granted beliefs which inform behaviour, the cultural integrationists have a further agenda. They aim to manipulate organisational culture to subtly control employees' beliefs and hence behaviour. Cultural control is a covert form of top down authority that can be just as directive and centralising as bureaucratic control. The author also maintains that cultural change programs alone cannot fix a problem that arose in the macro-economic sphere: a chronic lack of resources ever since the state responded to the economic crisis by cutting funds to health and welfare services.

A narrative by way of introduction

The Associate Professor asked me to do a workshop on organisational culture for one of the rural health services - "you're a sociologist - you know about these sorts of things". He explained that it was to be a series of staff development workshops and emphasised the importance of maintaining links with industry.

The workshop was held at an up-market holiday resort. After a quick look around I surmised that I had arrived at what is irreverently known as a 'love in'. The aim is to get organisational members physically away from the daily concerns and interruptions of the workplace to a politically neutral zone. The middle and senior managers had been instructed to wear casual clothes, as there were to be no symbols of rank. The resort stay reinforced status, and pulled on those strong cultural norms of reciprocity and obligation. Informal networking was encouraged to strengthen bonding and to facilitate team spirit. It was all part of a management change strategy that was referred to as an orientation program. From my experience in the field I tend to read 'indoctrination' whenever 'orientation', 'reorientation', 'the need for more education' or 'retraining' are mentioned.

In the interests of economic rationalism a radical restructuring was under way. Small rural hospitals had to go; downsizing, or the shedding of staff any way possible was the order of the day. In his rallying speech the CEO did not mince his words. He pronounced - "the hard decisions have to be made - if you won't make them (staff cuts) I will make them for you". To engender team building he added, "if we go over budget my job is on the line and your's with it. We are all in this together".

He talked about the importance of organisational culture and how the attitudes and beliefs of the old guard were hampering the success of the necessary changes. I was soon to hear my real agenda; an agenda for which I was unprepared, when he announced that I would be able to tell them how to create that positive and binding organisational culture which would have everyone working in the same direction - proud to be a part of the Big River Health Service.

I was 'put on the spot'. My main problem was one of faith. I cannot believe that the latest management theory, the 'cultural fix' can overcome the crippling lack of resources in the health services. Manipulating an integrative culture is an incredibly tall order given the subterranean nature of most assumptions which inform behaviour, let alone the historically entrenched culture of the health services. The class and gender segmentation of the health workforce poses particular limits to creating that one integrating culture about which the CEO spoke. Health professionals have different training and career structures. Some belong to unions whilst others, who see themselves as independent practitioners as opposed to wage-labourers, belong to professional associations. The latter tend to give their loyalty to their profession before the organisations in which they practise. Health professionals are socialised into different professional cultures which have a language of their own. These occupational communities form subcultures within health service organisations with their own rituals, heroes, demons, myths and legends. The material and political interests of segments of this most status-anxious of workplaces both creates and reproduces subcultures which hold different values; subcultures which can be in a constant opposition to one another.

Not that I disagree that some of the cultural beliefs which inform behaviour in the health services are out of fit with contemporary objectives. I will argue that some of the health services' rituals and practices are particularly pointless given their own objectives (such as team work, problem solving, self discipline, independent learning) whilst others - those which risk being lost - have been, and continue to be socially positive for human service organisations. Nor do I maintain that cultural change is not possible. Cultural change is continuous; look to women's acceptance into the workplace; albeit slow, and certainly not total.

Apart from seeing economic rationalism as goal displacement in any human service industry I am what Martin (1985) terms a 'cultural purist' as opposed to a 'cultural pragmatist'. The pragmatists treat organisational culture as just another organisational variable like structure or technique to be manipulated. They have put enormous sums of money into creating a uniform culture of excellence through a contrived involvement, re-education and rewards (see Dunford 1992:186-189; Burnes 1996:Ch 4). Kennedy created rituals, legends and stories to reinforce his nominated core values in a planned cultural change strategy (cited by Dunford 1992:187). The cultural purists on the other hand use the onion metaphor to explain the many layers of organisational culture; the deeper layers of which reflect the culture of the wider society; assumptions which are largely unconscious and therefore unquestioned; taken-for-granted world views which are beyond an easy access.

Methods used by the cultural integrationists

The strategies used by the cultural change agents were brought home to me one day in class when two young students took over my tutorial and turned it into the quintessence of a Billy Graham crusade. With evangelical zeal they stood up and pronounced "we are proud to be IBMers". How had IBM engendered such loyalty? Firstly these two young people had been selected from hundreds of other young employees as 'management material' to be 'fast tracked' through the course. They were given considerable help along the way, such as time off work to complete assignments and to study for examinations. The process is similar to the way some of the more successful religious sects engage new members. They dominate the every waking hour of members' lives and if new recruits are prepared to see the world their way they will be rewarded by being provided for materially as well as given respect and a sense of belonging to a community. Similarly, Omega Trend, a large pyramid selling organisation organises mass rallies and a mandatory social life for all its members (personal communication).

Advocates of cultural integration (the 'cultural excellence' school: Moss Kanter 1983; Peters & Waterman 1982; Deal & Kennedy 1982) maintain that a strong culture generates commitment and purpose in all organisational members. Strong culture is defined as all members adhering to the core values of the corporation. Shared values and beliefs are claimed to engender belongingness, co-operation and consensus, which the advocates of cultural excellence believe translates into increased productivity and profits.

The advocates of cultural integration do not couch their strategies in terms of control and yet it is obviously very beneficial for employers to be able to draw upon such cultural hegemony - to know that employees have internalised the company's values as their own. There is no need for a bevy of inspectors or correctors, vetting and checking employees' work. Self regulation through adherence to the cultural norms of the company has the potential to increase productivity because it means that employers probably can do away with those middle managers whose role was mainly surveillance and a capital cost to production. Cultural control allows flatter structures. Peters and Waterman (1982) maintain that culture can be the glue that binds the organisation together. With this cohesive glue, they contend, you do not need to be as concerned with all those bureaucratic structures designed to control outcomes. Cultural norms now become the centralising mechanism which allows decentralisation of the organisation. In other words employees can be entrusted to carry the company line even when away from the tight controls which were a feature of bureaucratically structured organisations.

Theories of cultural control

Cultural control has been an important component of theories of power since Marx referred to false consciousness (Bottomore & Rubel 1963:62). At the turn of the century Weber explained how religious beliefs were linked to material interests and the poorer stratum did not resent the wealthy because their advantage was seen to be legitimate (Gerth & Mills 1948: 276). But it is Gramsci's theory of cultural hegemony which best explains the sort of unacknowledged cultural control used by management strategists today. In the 1920s Gramsci explained the lack of revolutionary zeal in oppressed Italian factory workers as an unconscious consent to the cultural mores of a ruling elite; consent being so much better at control than coercion (Gramsci edited by Hoare & Newell 1971).

Apart from this present manipulation of culture for control within organisations this sort of unobtrusive power has been particularly influential in the health services. The lower segments of the health service hierarchy have accepted without question their lowly position. They view it as only right and natural that their work is less valuable. Lukes (1974) drew on and expanded Gramsci's theory. Lukes maintains that you do not need to observe two parties in conflict for power to be exercised. Some people or parties are so powerful that they can decide what appears or does not appear on a political agenda. That is, they decide what is a legitimately contestable issue. For example, female nurses' lowly position was not seen as a politically legitimate issue by female nurses themselves until long after the women's movement. Whilst there were always pockets of resistance it was not until 1983 that the Victorian Nurses' Union mounted industrial action which had the support of most members (Gardner & McCoppin 1987).

The cultural hegemony of the health services will make it particularly difficult for the CEO to impose a new hegemonic order.

The power of traditional culture in the health services

The health services have a long history of traditional beliefs; the logic of which is rarely open to conscious scrutiny. Traditional culture, in particular is the most difficult 'to get a handle on' because as Weber explains it is rarely questioned (Gerth & Mills 1948:ChX1). Whenever people say, "we do it this way because we have always done it this way" or "always has been always will be" you know that traditional culture is in operation. Traditional culture abounds in the acute care hospital, particularly the rural hospital. As noted in one history of nursing "*Handmaidens and Battleaxes*" (Gillespie, 1990), nursing was born in the church and bred in the army; both institutions of bureaucratic control and patriarchal order. Whether functional or dysfunctional for health workers or their clients this traditional culture is very difficult to change. For example, cultural

expectations of women in the health workforce have militated against women being recognised or fairly remunerated for their effort, knowledge, the highly responsible nature of their work, the emotional labour involved or their skills.

The 'cultural fix'; the new fad of the 90s

In nominating culture as his main obstacle to restructuring the Big River Health Service the CEO was echoing the present concern of other leaders in public sector organisations. At about the same time, Police Commissioner Ryan stated that he believed that the culture of the 'old guard' was his most pressing challenge in the restructuring of the police force (ABC News 27.2.98). Recently, after several much publicised client tragedies the Director General of the NSW Department of Community Services (DOCS) was sacked by the Carr Labor Government and replaced by Carmel Niland who has a background in welfare services and a management consultancy specialising in cultural change and workplace behaviour. Niland (ABC News April 98) stated that she would change the culture of the organisation; that staff were demoralised, feeling unacknowledged and unloved. Adele Horin (SMH 2.5.98 p45) pointed to the economic problems plaguing DOCS; problems the result of a series of government cut backs in funds, a chronic shortage of resources and persistent staff shortages. Given this lack of resources it is understandable that staff are feeling unloved. If human service workers are in any way conscientious and they are unable to do their job properly because of lack of resources (one of which may be time) than, staff will feel that the people who control the resources neither care about them or their clients. 'Love' alone or even trying to instigate a culture of care will not solve a systemic economic problem.

Habermas, a German social philosopher maintains that it is a dysfunctional feature of late capitalist societies that economic problems are not dealt with in the economic sphere in which they arose but are displaced into the socio-cultural sphere (1976). Labelling an economic problem a cultural problem does not find a ready solution.

The CEO felt so strongly about the need to address the problem of 'culture' (he was no more specific than this) that he set-up a working party to study the culture of the health service. 'Culture' was identified as both the problem and the solution; the 'cultural fix' was to be the answer. This contemporary trend is fascinating given that the term 'organisational culture' did not appear in the mainstream organisational behaviour literature until the 1980s.

The 'old guard'

Today with the prominence of cultural change strategies, the longest serving members of the organisation are being labelled as 'old-fashioned fuddy-duddies' and being accused of 'wrong-thinking', and of being fixated in 'mind-sets'. These stalwarts of the organisation are taking the rap for lack of progress - however progress is defined. In the health service under study it is the very experienced and therefore middle-aged female nursing managers who have been offered redundancies or early retirement. It did not take any sophisticated methodology to note the relatively young age of the senior managers. It was obvious that men outnumbered women at the senior levels. Traditional values concerning gender relations are more apparent in the country and this was expected. The relative youth of the senior managers fits with the Australian tradition termed 'spiralling'. 'Spiralists' are ambitious young managers who apply for a senior position in a small rural health centre where there is little competition. They plan to secure a middle management position in the city as soon as they can claim enough senior management experience.

Critical theory methodology alerts us to look at all angles of social phenomena, both positive and negative. Gouldner gives both a damning critique and reaffirmation to the beliefs and values of the old guard (1979). Just when he has you thoroughly convinced that the old style bureaucrats were moribund, rule-bound, inflexible time servers he reminds you of the very socially advantageous values that they held in common; values that have all but been lost today. When religion was practised communally most members of the community took the concept of a vocation or calling to heart. Realising your God-given gift and doing your duty to the best of your ability took precedence over remuneration or creature comforts. Business people abided by an ethic

of value for money. Nurses who trained and worked in the religious hospitals tell me that the words 'your patient comes first' became a mantra. The economic rationalist dogma of the 90s is an anathema to these people. They are experiencing stress in that they can no longer do their job to the best of their ability as resources, both human and material are constantly being whittled away. They are virtually not allowed to 'give' which is an important manifestation of their commitment. It is impossible not to compromise quality in the face of never-ending cutbacks. The contemporary slogan 'work smarter not harder' or admonitions to improve your time management are insulting to people who are experienced administrators and who know what hard labour is. Rather than being rewarded for years of loyalty and efforts to maintain standards these people are the first to be targeted in what is euphemistically called 'downsizing'.

Management 'science' and the need for raised justifications

It is ironic that the cultural change merchants of today aim to get back to the sort of total commitment that comes from religious conviction. They expect employees to put in long unpaid hours to demonstrate their loyalty and commitment to the company. It is interesting to note the way religious ideals have been incorporated into the language and strategies of the North American cultural excellence school. In her video 'The Change Masters' Moss Kanter speaks of the leader's vision and mission with evangelical zeal (1983). The transformational leader advocated in the literature has apriori qualities of charisma and greatness with many people willing to follow them, as did the religious prophets. The strategy of the cultural excellence proponents reflects and draws upon the culturally embedded, but uncoupled from theology, major religious tenets of the Calvinists. Not giving your best, irrespective of calling or vocation, was to cheat on God and jeopardise salvation. Hence the notion of relentless work. God and his temporal representative have now taken on a secular form: the corporation and its leader.

Habermas' theory of the modern day motivation and subsequent legitimation crisis is telling here. Religious beliefs and traditions were the most powerful motivators in pre-capitalist times and although religious beliefs have become progressively subjectivised away from communally held and practised beliefs Habermas maintains that they continue to be drawn upon as motivators because positivist science has produced no 'functional equivalents'. Management science is a case in point. As soon as one method has gained dominance with all concerned believing that the organisational analysts have arrived at the one best universal way to manage, another theory with the same promises comes into dominance to usurp and debunk the old theory and/or method. Hence a belief in management science does not have the same endurance of pre-capitalist beliefs and values. Habermas wrote that '... traditions being eroded no functional equivalents for the spent traditions, for they are precluded by the logic of development of normative structures' (1976: 76). He maintains that late capitalist societies are therefore left with 'a peculiar mixture of pre-capitalist and bourgeois elements of tradition'. Contemporary motivators need to be backed up by religious tenets as capitalist ideology cannot produce enough consensual motivators for itself: it needs to 'feed parasitically on the remains of tradition' (1976:76). As various scientific revelations are vying for normative status it leaves post-industrial society with the need for 'raised justifications' that in turn cause political legitimation to be more problematic than in pre-capitalist times. Habermas' theory both explains and predicts the way management theories go in and out of fashion vying for dominance and legitimacy.

Further proof of the endurance of religious beliefs which have become uncoupled from religion, is the moral imperative contained in economic rationalist policies. 'Sloth' and 'waste' continue to be the two deadliest of sins even though the number of practising Protestants has dramatically declined. In not having the faith, in not being a true believer I found myself in a most unenviable position at the 'love in'.

Ideal and material interests

The CEO nominated customer service as a core value. I argue that to have everyone across the organisation adhering to this core value will be particularly challenging. Firstly, as seen in the case of DOCS, a restricted budget is incongruous with improved customer service and in constantly demanding more high quality service

from staff who do not have the resources, managers are producing additional stressors. The second challenge to this planned value consensus is the material interests of some individuals and groups in the health services. Whilst individual health workers may adhere to a 'your patient comes first' ideology and put in additional unpaid hours of work (perhaps more in terms of patient advocacy than loyalty to the organisation) others may be more motivated by the lucrative incomes that can be made by some segments of the health workforce. Stuart Rees (1986) maintains that the material interests of some medical doctors often come before patients' interests. He gives as his evidence the 1984 doctors' dispute in which he contends the doctors as a militant group (The Australian Medical Association) used their patients as hostages to hold the government to ransom in a bid to maintain their privileged position and superior incomes.

An analysis of ideas and beliefs surrounding decision making in the health services

The CEO stated that he wanted senior managers to be decisive; to make the hard decisions, specifically referring to redundancies. The nurses responded that they had no experience in high level decision making.

Rules about who has the right to make which decision are very black and white in the health services; some proscribed by law. At one level this is understandable, as managers cannot allow health workers to take risks or learn from their mistakes where human lives are at stake (whereas risk taking is exactly what is advocated in the literature to enhance entrepreneurial activity). The community only wants knowledgeable and experienced people making decisions which will effect their health. But at another level if health professionals are barred from making decisions which are within their knowledge domain this is an under utilisation of their knowledge and experience. In the health services today there is a whole gamut of decision making that remains by law the exclusive domain of doctors: decisions about diagnosis, treatment, surgical intervention, admission and discharge, to name but a few. Doctors' control over decision making is robbing other health professionals of the opportunity to practise their craft. The universities are now hyper-skilling health professionals and yet medicine continues to deskill their practice (Herdman 1998). For example, medical radiation technology students are today examined on their diagnostic ability but once out in the workforce diagnosis is the legal domain of radiologists.

Taking responsibility in decision making is also an issue. Many health workers have expressed to me that they prefer that the rules regarding decision making are 'set in concrete' because they know exactly where they stand and are not likely to unknowingly step out of their domain and face reprimands or have to answer to a tribunal. This is because the penalties for acting out of your domain whether it is an inappropriate decision or not is so much more severe for uniformed staff than for non-uniformed staff. Doctors, although as open to legal liability as other health professionals do not come under any scrutiny from other health workers, as by law they can only be disciplined by members of their own association.

To understand how medicine has come to have such hegemonic sway over the population it is necessary to do a political and historical analysis. Very briefly, the modern day doctors who prior to the various Medical Registration Acts in the six Australian colonies (pre-Federation 1901) were unregulated practitioners known as allopaths did not always enjoy such medical sovereignty. They managed to take sovereignty over the other health practitioners such as homeopaths, apothecaries, barber-surgeons and midwives, all of whom were independent practitioners- late 19th century. Most importantly they established scientific legitimisation for their profession by aligning themselves with the scientific revolutions at the time. The implementation of mass immunisation and other advances in public health such as sanitation and clean water made an impact on the health status of populations. Infant mortality dropped and more people were living to older ages than ever before. The allopaths claimed responsibility for these advances and yet if you go further back in history they were not particularly scientific believing in such pseudoscience as miasma theory (Willis 1989:Ch3,8; Davis & George 1998:Ch 5).

The other crucial legitimisation achieved by the allopaths on their road to medical dominance was state patronage. Once the state put laws in place to restrict the use of intrusive treatments, surgical instruments and drugs to qualified and registered doctors it excluded other health practitioners from independent and

autonomous practice. Willis (1989) explains how medicine, with the backing of the state managed to subordinate, limit, exclude and incorporate the work of other health practitioners.

The politics of decision making is gendered in the health services. Although today, more men are joining the previously feminine health occupations such as nursing, physiotherapy and occupational therapy, and women are entering those health occupations previously designated for men, occupations in the health services continue to be gendered. The members of those occupations dominated by men enjoy more status, prestige and income. The predominantly male medical profession continues to hold a position of dominance over the female dominated nursing profession. Men continue to be over represented in nursing management, health management and clinical management (Palmer & Short 1994:Ch6; Gardner & McCoppin 1995: Ch 14).

The health workforce hierarchy is also divided along class divisions, with the elite health professionals - the medical doctors - being drawn predominantly from the privileged classes, both in terms of physical and cultural capital. This structured inequality is the impetus for those subordinated sectors, who can see through male medical hegemony, to be engaged in a continuous struggle for recognition of their skills and the right to practise autonomously. Hence the struggle undertaken by the nurse practitioners and independent midwives to practise independent of doctors (Willis 1994; Willis 1989; McCoppin & Gardner 1994; Gardner & McCoppin 1995).

Given this systemic inequality of health service education and right of practice, how realistic is it to expect all health practitioners in the one health service organisation to share the same core values and beliefs - to rise above their political and material interests? Cultural integration as advocated by the cultural strategists is yet another management fad presented as the universal solution to problems of productivity in a recessionary age.

Ideas and beliefs surrounding authority and deference in the health services

Newcomers to any organisation are more likely to see the distinctiveness of an organisation's culture before they become enculturated. To explain the 'taken-for-granted' nature of organisational culture to my audience of health workers I related my own experience of working in a university school of health services management. My colleagues, who had spent many years (most as nursing managers) in the health services before their academic careers, were unaware that they had imported nursing culture into the school. For example, they all observed morning and afternoon tea rituals. A full one-hour was observed for lunch. Whilst ritualised work and rest periods were somewhat quaint, their shared ideas concerning authority and deference were a little more insidious. They had enormous respect, or maybe they feared (through experience) positional power. They gave unconditional loyalty to the dean, heads of school and other high-ranking academics. These senior academics did not have to earn respect or loyalty from their subordinates as in other academic communities, because in a bureaucratic manner staff gave loyalty and respect to whoever held the position. Hence the senior academics came under none of the usual checks and balances such as gossip or the more public demands for accountability or even rejection of their line management function. This gave the executive considerable power because they could virtually make decisions without any fear of reprisal. There were no disclosures of discord to confidants; the grapevine was unusually silent on senior executive decisions, personalities or behaviour.

All conflict with high-ranking academics was between atomised individuals. That is, if any one member of staff disagreed with a decision by an executive they had to confront this person alone because their colleagues, no matter what they thought of the decision or the personal qualities of the senior manager would not speak out or lend support; would not form a coalition. It was almost as if their whole career depended on their good personal relationship with one or two executives, much more than their academic achievement. Sycophantic behaviour was rife. Perhaps through experience they knew not to confide in anyone; to be on the alert; not to say anything that could be used against them at a later date.

Hence, belief in ideas about the importance and power of positional authority continues to hold sway in some segments of the health services. These ideas can only be thwarting such contemporary objectives as involvement, power sharing and participatory decision-making, which are often stated as the means to facilitate cultural integration.

It is ironic that the nurses' attitude to positional power is only partly out of fit with the new cultural integrationist agenda. The CEO will continue to have loyal followers by virtue of his position, more than his

vision and/or mission. The cultural integrationists are often as mechanistic and as centralising as the classic school of management, particularly in regards to what they expect of a leader. Like Taylor's managers in an earlier era, the leader is expected to keep everything running smoothly, and is held ultimately and solely responsible for the success or otherwise of the organisation.

Ideas and beliefs surrounding discipline in the health services

Discipline was another more in the health services that had a distinctive interpretation. I observed that discipline - specifically the need for externally imposed discipline - was a very important shared belief amongst some segments of the health workforce. Not self-discipline but the diligent attention to broadcasting the penalties and sanctions which would surely be applied without fear or favour if subjects were found to break the rules. This externally imposed discipline was understood as necessary to maintain order by all; both the supervised and the supervising. For example my students from the health services (particularly those from the paramilitary sections) expected and needed externally imposed deadlines, mandatory directives and the threat of penalties to keep them motivated and on-track.

I came to realise that the imposition of discipline was a ritualistic game played by two parties who both knew the script and the moves. This game even has its own language. The game always begins with a clear dissemination of the rules and penalties for breaking the rules - colloquially known as 'reading the riot act'. This covers the rule enforcer from any accusations of prejudice as the rule enforcer can always say - 'you were told - its on your head'.

Once it has been discovered that a subordinate has broken a rule, or rather ignorance can no longer be maintained the law enforcer must apply the penalty or risk being labelled 'easy'. Both declare that the rule breaker's actions have been discovered; have been 'sprung'. It is the next move in this game which is the most fascinating because usually you would expect someone who has broken a social rule to feel guilt or remorse. Ordinarily you could also expect the person doling out the punishment to feel badly and to worry about the possibility of being accused of singling one person out in a prejudicial way or even of being inhumane or 'hard'. But the next stage exonerates all guilt for both parties and allows both to save face. The rule breaker needs to admit that she/he knowingly broke the rule - 'owns up' - and states that she/he is prepared to take the penalty; that she/he is prepared to 'cop it sweet'. The supervisor is expected to be impressed by this honest admission and any bad feelings on either side are exonerated. The supervisor saves face as she/he is publicly seen to be applying the penalty without fear or favour and hence maintaining order.

In terms of the strategic goals of any human service industry today the ritualised repetition of the discipline game appears to be particularly pointless. How are the human services - particularly health - ever going to instil self discipline, self direction or encourage independent thinking or learning in their members if this tradition is maintained? Do they really believe that chaos will reign if the ritual is not enacted daily? This form of paramilitary control is certainly going to thwart the CEO's attempts to replace such external control by self control; the self control which is expected to flow on from everybody internalising and therefore conforming to the core corporate values.

Beliefs about the necessity of vigilant external discipline will be difficult to undo because as I have demonstrated the discipline game is neither rational nor functional today. Cultural analyses show the irrational face of organisations. People hold on to their beliefs and re-enact the rituals communally because they are meaningful. Perhaps it is the show and reaffirmation of rank and status that is meaningful in this ritual. Even in these days of economic rationalism health workers continue to behave in ways that are not the most logical, expedient or cost effective.

In the health services there is a class and gender dimension to the discipline ritual. It is only for the uniformed staff; the para professionals. The elite professionals - the doctors and senior managers - are immune from the ritualistic discipline game. They take part in different status reaffirming rituals. Whilst the senior managers may have to answer a ministerial inquiry or answer to share holders, doctors can only be disciplined by their own professional association. The majority of doctors working in hospitals are Visiting Medical Officers paid on a contractual basis and therefore not seen as members of the organisation who come under the bureaucratic rules and regulations of the organisation.

Like decision making and authority, the ideas and beliefs surrounding discipline in the health services are not shared across an organisation. Different subcultures adhere to different interpretations according to their political and material interests.

I went ahead with my planned presentation and workshop, including a critique of the cultural integrationists and pragmatists. During the workshop participants completed an exercise from Richard Dunford's text "*Organisational Behaviour*" (1992:183). The exercise requires participants to do a cultural diagnosis by analysing themes. For example, under the theme 'autonomy' participants were asked - is it provided or does close monitoring occur? Other themes such as 'conflict', 'information', and 'criticism' were analysed. The middle managers were keen to do the exercise, to bring to conscious discussion that which had always been taken-for-granted: "this is the way we do things around here". They realised that 'the way' was not always functional for all parties. In particular they were not happy with the way conflict was handled. I was invited back, to one of the networks where I worked together with staff to reveal and assess the worth of cultural beliefs which inform their practice. Here I felt that I was doing the work of a sociologist because cultural analysis is important; it can reveal the informal organisation of shared values and beliefs that were by-passed by the early rational/functionalists. Analysing organisational culture gives a much fuller and more realistic understanding as to why people do what they do in organisations. The intent of our cultural analysis at the workshop was very different to the manipulated cultural control of the cultural integrationists.

Conclusion

The interest in cultural analysis of behaviour in organisations since the 1980s has given a much richer understanding of human behaviour in organisations than the earlier schools of management which only studied the formal, rational and obvious aspects of organisations. It is the intent of some of the cultural analysts of organisations which has been questioned in this paper.

The cultural integrationists have taken the concept of 'culture' uncritically from the functional anthropologists and used it in a pragmatic and instrumental way to manipulate a commitment to the corporation which they believe will boost productivity and hence profits. They do not couch their strategies in terms of control, and yet they aim to replace the obvious and much maligned top-down bureaucratic control with the less obvious but just as centralising cultural control. In believing that they can over-ride existing culture, particularly in the health services, they are as open to criticism as the early anthropologists who only understood culture in an ahistorical and apolitical manner. As Wolfe (1982) explained, the early anthropologists took a snapshot of an indigenous culture assuming that the culture had been static for generations with a very simple and unchanging political organisation. This paper has argued that you cannot understand the manifestation or endurance of a presenting culture unless you do an historical and political analysis. Only a political deconstruction can reveal that which is hegemonic. The vying for power and legitimation between the various health professionals maintains subcultures which are in a constant opposition to each other. This coupled with the traditional culture of the rural health services poses definite limits to the imposition of a contrived hegemonic order.

The over-riding problem in health services today is one of insufficient resources. The state's response to the economic crisis (rolling back the welfare state) is the source of today's problems and yet, crises that arose in the economic sphere continue to be displaced into the socio-cultural sphere. The 'cultural fix' at the micro level is yet another example of looking for answers in the wrong place.

References

- Australian Broadcasting Corporation 1998, *News*: Channel 2, 7.00 pm, 27 January 1998.
- Bottomore TB & Rubel M (Eds) 1963, *Karl Marx: Selected Writings in Sociology and Social Philosophy*, Penguin, Harmondsworth.
- Burnes B 1996, *Managing Change: A Strategic Approach to Organisational Dynamics*, Pitman Publishing, London.
- Davis A & George J 1998, *States of Health*, Harper, Melbourne.

- Deal TE & Kennedy AA 1982, *Corporate Cultures*, Reading Addison-Wesley, MA.
- Dunford R 1992, *Organisational Behaviour: An Organisational Analysis Perspective*, Addison-Wesley Business Series, Sydney.
- Gardner H & McCoppin B 1987, 'The politicisation of Australian nurses: Victoria 1984-1986', *Politics*, 22, 1: 19-34.
- Gardner H & McCoppin B 1995, 'Emerging militancy: The politicisation of Australian allied health professionals' in Gardner H (Ed) *The Politics of Health: The Australian Experience*, Churchill Livingstone, Melbourne.
- Gerth HH & Wright Mills C 1948, *From Max Weber: Essays in Sociology*, Routledge and Kegan Paul, London.
- Gillespie R 1990, *Handmaidens and Battleaxes*, Ronin Films, Sydney.
- Gouldner A 1979, *The Future of the Intellectuals and the Rise of the New Class*, Macmillan, London.
- Gramsci A 1971, *Selections from the Prison Notebooks of Antonio Gramsci* edited by Quinton Hoare and Godfrey Newell. Lawrence and Wishart, London.
- Habermas J 1976, *Legitimation Crisis*, Heinemann, London.
- Herdman E 1998, 'Knowledge without power: The professionalisation of nursing' in Keleher H & McInerney F (Eds) *Nursing Matters: Critical Sociological Perspectives*, Churchill Livingstone, Melbourne.
- Horin A 1998, 'Nursing Docs' *The Sydney Morning Herald*, 2.5.98, p.45.
- Martin J 1985, 'Introduction'. in Frost PJ, Moore L, Louis MR, Lundberg C and Martin J (eds) *Organisational Culture*, Sage, Beverly Hills CA.
- McCoppin B & Gardner H 1994, *Tradition and Reality: Nursing and Politics in Australia*, Churchill Livingstone, Melbourne.
- Lukes S 1974, *Power: A Radical View*. Macmillan, London.
- Moss Kanter RM 1983, *The Change Masters*, Simon & Schuster, New York.
- Palmer G & Short S 1994, *Health Care and Public Policy: An Australian Analysis*, Macmillan, Melbourne.
- Peters TJ and Waterman RH 1982, *In Search of Excellence*, Harper & Row, New York.
- Rees S & Gibbons L 1986, *A Brutal Game: Patients and the Doctors' Dispute*, Angus & Robertson, Sydney.
- Willis E 1989, *Medical Dominance*, Allen & Unwin, Sydney.
- Willis E (Ed) 1994, *Illness and Social Relations: Issues in the Sociology of Health Care*, Allen & Unwin, Sydney.
- Wolfe E 1982, *Europe and the People without History*, University of California Press, Berkeley CA.

Commonwealth Brief

This issue of Commonwealth Brief is devoted to the National Demonstration Hospitals Program. The Program is a Commonwealth initiative that was established to identify and disseminate information about best practice models for innovation in acute hospital care. The effectiveness and transferability of NDHP innovations are explored and evaluated through demonstration projects in a range of public hospitals located in all States and Territories.

The paper presented below was written by Amanda Alexander, who has worked with the National Demonstration Hospitals Program since its inception. Her initial role was as manager of the NDHP Phase 1 pre-admission project at the Royal Melbourne Hospital. The project implemented systems and processes to ensure that patients' health was optimised before admission. Towards the end of Phase 1, Ms Alexander took over the Review of the Program and wrote Towards Best Practice in Elective Surgery. Ms Alexander also conducted the qualitative Review of the NDHP Phase 2 and wrote Managing Beds Better - Balancing Supply and Demand. She is currently working on the NDHP Phase 3 Review.

For further information on the Program, please contact members of the National Demonstration Hospitals Program project team on (02) 6289 8712.