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Organisational development in a rural hospital in Australia

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Abstract

Objective. This paper analyses an organisational development project that aimed to change the organisational culture and improve people management systems and processes. The questions addressed were: was the change process a success; how was success defined; and what were the barriers to its progress?

Methods. We examined the process of change over a 3-year period. The organisational development intervention is described and analysed. Qualitative methods, including document review, in-depth interviews and focus groups, participant observation, newsletters and diary entries were used to gather the data. A variant of competing values was used to analyse the data.

Results. We sought to build trust with all managers and encouraged reflection by conducting feedback sessions, presentations, workshops and one-on-one and group discussions. A cross-site action group was established to encourage organisation-wide participation in the project. However, it was clear that stakeholders had different understandings and perceptions of the problems facing the organisation. The project faltered when a leadership development intervention was organised.

Conclusions. The existence of at least four different organisational 'worlds' and identities, according to different professional groupings with different goals, languages and values, was evident. The relationship between the researcher and subjects was key in terms of whether the researcher is seen as an 'expert' or as a 'facilitator'. In bringing about change, we need to work with the Chief Executive Officer in empowering others. Hence, the researchers need to engage in continual dialogue across boundaries and within groups as well as at individual levels to provide support for organisational change.

What is known about the topic? Evidence suggests that change processes often fail, that success in one part of the organisation may not translate into organisation-level performance and that change may fail to deliver expected organisation-wide results. Fluctuating organisational expectations may render managers unable to understand the shifting world and the confusion, anxiety and stress that middle managers experience as part of the change process may impede decision making.
What does this paper add? This paper reports on a single case study of an organisational development project in a rural health service in Australia. The contribution of this paper is in demonstrating the different worlds of each of the actors involved. Moreover, it shows that building relationships is key.
What are the implications for practitioners? The relationship between the researcher and subjects is key in terms of whether the researcher is seen as an 'expert' or as a 'facilitator'. The researchers need to engage in continual dialogue across boundaries and within groups, as well as at individual levels, to provide support for organisational change. The research also demonstrates the importance of middle managers in facilitating communication between senior management and employees.

Additional keywords: boundaries, health care, human resource management.

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Introduction

Public hospitals worldwide continue to experience fundamental changes as governments have introduced more stringent accountability measures to increase efficiency, effectiveness and improve service quality.[1,2] Some health organisations have responded by using 'quick and dirty' approaches to organisational change, whereas others have drawn on more inclusive and more time-consuming organisational development (OD) approaches.[3,4] OD

is time consuming because it emphasises the importance of involving employees in change and decision-making processes.[5] However, whatever approach is used, the evidence suggests that success is rare[6] and that change projects can create confusion, anxiety and stress that impedes and paralyses effective decision making.[7]

This paper reports on a single case study of an OD project in a rural health service in Australia. The researchers were actively engaged in facilitating the change process over 3 years. This health service was perceived by government and accreditation agencies as a low performer for poor financial, throughput and quality outcomes and high levels of industrial disputation. In 2004, the hospital scored poorly in the Australian Council on Healthcare Standards independent accreditation process and had a serious adverse event that was related to inadequate clinical risk management. The seriousness of the adverse event and perceived mismanagement led to scrutiny by the state government and health accreditation bodies. Consulting studies funded by government to improve performance identified issues with organisational structures and processes, suggesting that the management had not kept up with the growth in staff and services. The consultants also reported a high level of staff disengagement and dissatisfaction. As a response to these investigations, the organisation introduced a new more decentralised organisational structure in 2004 and Executive Directors were employed in key functional areas.

Subsequently, the hospital approached the university team in an attempt to improve the organisation's performance. An initiative was designed as a joint project between the agency's senior management team and a team of university researchers. It has been noted that public sector change has often been unsuccessful due to embedded practices, bureaucracy, frequently changing senior leadership and the complexity of reforms.[8] In exploring and analysing the successes and failures in this case, we draw on change models and literature as well as health literature to investigate why the OD intervention did not proceed according to plan.

The structure of this paper is as follows: first, we explore the literature; second, we outline the case study context; third, we describe the OD intervention; and fourth, we draw conclusions. We embed our qualitative methodology of in-depth interviews and focus groups, and researcher observation as active participants in the project, into this story and into the analysis. For confidentiality we have named this agency Gum Leaf Health Service.

Literature review

Understanding forces that cause resistance, and programs and strategies that will increase motivation are essential in any change process.[9] In this, the role of change agents such as top managers, middle managers and operational staff are key. Lüscher and Lewis[7] argue in particular that middle managers are the lynch pins of organisational change because they operationalise change initiatives aligning their units to top management mandates. Higher managers' contact with employees often relies on middle managers as intermediaries and boundary spanners, whereas front line managers look to middle managers for sense making.[7] Evidence suggests that change processes often fail,[10] that success in one part of the organisation may not translate into organisation-level performance[11] and that change may fail to deliver expected organisation-wide results.[6] Fluctuating organisational expectations may render managers unable to understand the shifting world[12] and the confusion, anxiety and stress that middle managers experience as part of the change process may impede decision making.[7] Participants often struggle with changing roles, processes and relationships, rendering decision making and action problematic.[7]

An OD approach recognises participants as proponents of change as well as the limits on their actions due to the organisational environment and resources. In theory, OD is a systematic approach with a key objective being to create an adaptive organisation that achieves excellence by integrating individual desire for growth and development with organisational goals. A typical OD approach is based on a series of steps beginning with problem identification, moving through consultation and gathering of information, initial diagnosis, group feedback, joint problem diagnosis, joint planning of intervention, engagement and evaluation.[5,13] OD is not without its critics; Chisholm and Elden[14] argue that this traditional approach positions the change manager as expert who assumes primary oversight of the research design and data collection. They suggest that a more collaborative approach would involve sharing research and responsibilities, while leveraging the different knowledge of researchers and subjects. Edmonstone and Havergal[3] also question whether OD approaches are appropriate in healthcare interventions in that they may undermine shared values and often target individual behavioural change ignoring structural, technological and political factors. They point out that definitions of success have tended to be based solely on financial considerations rather than an evaluation of the process, its aims and the perceptions of those people involved, thereby not taking into account the diverging values among healthcare policy makers, managers and clinicians.

Despite these concerns, using an OD approach provides a processual framework that uses a sequence of events to frame change over time,[15] allowing for explicit and direct observations of the process in action and describing and analysing how the entity and issue develops and changes.[16] This is especially important where episodic change occurs as a result of a misalignment or event, as the sequencing of the change events affects receptivity by actors.[16] Hence, in this paper, we respond to Pettigrew *et al.*[16] and examine the order of events, as well as the relationships between the researcher and subjects. In doing so we take up Herbert Simon's[16] call for organisational change to deliver 'how to' knowledge through a more sophisticated and demanding engagement with practice, and we support Woodman's[17] argument that the gap between organisational change science and practice is the single largest impediment to progress in effective change management. The overall research questions addressed in this paper are: was the OD change process a success; how was success defined; and what were the barriers to its progress?

In addressing these questions, the paper uses the four world framework for the analysis of this case study.[18] Similar in concept to the competing values framework,[19] Glouberman and Mintzberg[18] expand on the conflicting values among the four major 'players' with an impact on organisational performance in a healthcare organisation. They argue that the 'world' of healthcare

has long been differentiated into four different worlds: four sets of activities, four ways of organising, four unreconciled mindsets, namely cure, care, control and community or doctors, nurses, managers and trustees, each looking in different directions (downward, upward, inward and outward). So long as these remain disconnected, they argue,[18] nothing fundamental will change. That is, no matter how necessary these divisions of labour may be, it is the associated divisions of organisation and of attitude, or mindset, that render the system problematic, with disconnections in unreconciled values, incompatible structures and intransigent attitudes.

Research site

Gum Leaf is a medium-sized rural healthcare service in a large state jurisdiction in Australia. Gum Leaf is publicly funded by a complex arrangement of Australian federal and state grants and funding streams. The service provides a range of acute, aged care and community health services across five geographic sites and has seen massive growth since the mid-2000s in terms of size, geographical coverage and service type. This growth was partly to do with amalgamation of services and partly to do with the entrepreneurial activities of the Chief Executive Officer (CEO) in securing new programs and services.

The service suffers from the usual problems of rural areas in terms of recruitment and retention of good quality professional staff across all areas. According to background documentation, the service had suffered from high number of industrial relations disputes and many problems with service quality, leading to a highly publicised clinical adverse event. Consultants, appointed by the State government to review the service, had identified issues with organisational structures and processes, suggesting that the management structures had not kept up with the growth in staff and services. High levels of staff disengagement and dissatisfaction were also reported.

The organisational response was to introduce a more decentralised organisational structure and employ Executive Directors in key functional areas. With the service under the constant scrutiny of the State government and a sense of crisis and urgency emerging from the investigations, the senior management team agreed to embark on a major OD project. The aim of the project was to develop an organisational change approach that focused on the people management practices, including systems, processes, policies, attitudes and behaviours, to improve and create an innovative and effective organisational culture.

Methods

The project received ethics approval from the University; the participating health service did not have a human ethics research committee process. Throughout the project, both individual interviews and focus groups were conducted by the university team with the boards of management, managers and staff to capture their opinions before the change process and then while it was occurring. Methods of data collection included: the collection and analysis of key documentation, including annual reports, human resource policy, newsletters and procedure manuals, and other relevant organisational reports; in-depth semistructured interviews and focus groups of a range of managers; staff workshops; and participant observation by the team. This team comprised five members (two associate professors, one each in health and management, two senior lecturers of management and a research assistant). The hospital managers included the board of managers and senior managers described as the Executive Team, and middle and line managers described as operational managers. As the OD intervention proceeded, ongoing discussions and presentations with the board of management, senior managers and line managers were conducted. Furthermore, staff workshops were conducted. In all, 10 interviews were conducted with the Executive Team and two focus groups were conducted with operational managers. These semistructured interviews, focus groups, workshops, presentations and discussions permitted the researchers to gather rich information on the change process from the perspective of a cross-section of managers and staff and allowed for a suitable cross-check of these data. Multiple perceptions about a single reality allows triangulation of several data sources that provide validity as researchers search for convergences.[20,21] An interpretivist approach was used to analyse the interview data as preferred when dealing with complex social phenomena. By examining the way people think and act, it removes bias by accurately describing the participants' meanings and interpretations of events.[22] All interviews were taped with the permission of the interviewees and the transcripts were analysed through a process of coding of the emerging themes in line with the theoretical framework.

We hoped to capture the priorities of a range of stakeholders and establish achievable objectives within the current environment and with the existing resources. We believed that an OD approach would encourage participation and ownership of change and would enable all change actions conducted by both the hospital and university team to be examined and reflected upon, assisting in embedding change into the organisation.

Results

The intervention

Stage one: readiness

The first stage involves determining that the organisation is ready for change. Often the organisation is inflexible and insensitive to the need for change, and questions to be asked here include those seeking to establish the readiness of the organisation and the people involved. A key element here is also establishing that the organisation is motivated to work on the problem. This is widely accepted in the literature as the stage of establishing a change sentiment, establishing that a sense of change is needed and creating a vision.[23,24]

Stage two: gathering and analysing the data

The second stage of organisational change projects consists of gathering and analysing data, identifying problem areas and overcoming resistance to change. Forces are identified within individuals and organisations that cause resistance to change programs and strategies are recognised that will increase motivation to change.[9]

Stage three: intervention

Intervention is the third stage and covers a variety of activities ranging from changes to processes and structure, through to

changes to people and behaviours. Process intervention can be used to help work groups become more aware of the way they operate and the ways members work together. Recognising the need for employee empowerment interpersonal interventionist can also be used, which uses an analysis of interpersonal and communication styles. Kotter[24] argues that effective implementation here depends on the need to form a powerful guiding coalition, to empower others to implement change and to create short-term wins.

Several meetings were held before the process commenced to define the scope, objectives and expected outcomes. The whole process included seven site visits and numerous phone calls and meetings with members of the Board of Management and senior management team outside of these visits. Methods of data collection included the collection and analysis of key documentation including annual reports, human resource policy, newsletters and procedure manuals, and other relevant organisational reports; in-depth semistructured interviews with four Board members, all six Executive Directors and focus groups of the middle managers. Overall, five staff workshops were held at each of the sites with approximately 15% of staff participating, and participant observation was undertaken by the university consultant team. The team collected staff feedback through email and produced three newsletters with information about the project and feedback from the findings.

Each visit was conducted over several days with visits to each site. Given the documented people management issues faced by the health services, the interview schedules were based on the research questions developed from the human resource management literature; these issues have been reported elsewhere.[25]

We hoped to capture the priorities of a range of stakeholders and establish achievable objectives within the current environment and with the existing resources. We believed that an OD approach would encourage participation and ownership of change with all change actions conducted by both the hospital and university team to be examined and reflected upon, assisting in embedding change into the organisation. We sought to build trust with all managers, thereby accessing undiscussable components of daily working life,[26] and enable effective collaboration by identifying patterns and categories that could be explored with the participants.[27] This occurred through reviewing intervention notes and interview codes and checking against existing literature and participants' perceptions and understandings. We also encouraged reflection by conducting feedback sessions with the senior management team (SMT) and the Board, middle management and staff through presentations, workshops and one-on-one and group discussions. Effective implementation depends on a powerful guiding coalition to empower others to implement change and to create short-term wins,[24] so a cross-site action group was established to encourage organisation-wide participation in the project, consisting of 12 board and management members. As Lüscher and Lewis[7] found, periodic interventions enabled subjects to articulate and question and to apply their learnings and understandings to practice.

In a traditional OD intervention, the researcher is positioned as the expert; however, in adopting a more collaborative and embedded approach, we, as external facilitators, aimed to provoke discussion and critical enquiry to disrupt established ways of thinking, test established practice and relationships and provide a context for subjects to reflect and change.

However, even at the early stage it was clear that stakeholders had different understandings and perceptions of the problems facing the organisation. Board members highlighted the need for substantial organisational improvements, however the problem was narrowed to a human resources (HR) problem:

> *As a Board we want to establish some useful criteria to monitor HR and HR performance in our organisation – benchmarking relationships – ensure the organisation is at the cutting edge.* (Board Member)

Staff perceived the problem to be a wider issue of poor management, one staff member describing the management as being in 'panic mode'.

As the process developed further, differences emerged: although SMT members claimed they were open to identifying the problems and discussing possible solutions, the middle management participants expressed a lack of trust and suspicion regarding the project and the SMT.

Similar concerns arose in a focus group of middle managers:

> *What we want to see is good communication*, *caring*, *evaluation*, *being involved in decision making*, *and formalised KPIs* [key performance indicators] *down to the individual level . . . The previous review highlighted a lack of transparency and it has gotten worse. There are not minutes taken anymore. We don't know management's goals.* (Department Managers)

Lack of communication across the organisation emerged as a key issue and some managers were uncertain about expressing their views.

Workshops were held with a newly established HR management (HRM) committee whose role it was to improve the organisation's policies and procedures and to improve accountabilities and management. This committee, we believed, would also assist in legitimising the need for cultural change and we encouraged workshop participants to analyse the HRM functions within the organisation. With evidence from the interviews and focus groups, people management was identified as 'ad hoc' and inconsistent across the organisation, with gaps in expected HRM functions. In exploring the concept of 'employer of choice', which had been raised by the SMT as important for recruiting and retaining staff, staff spoke of their general sense of isolation, with lack of communication and interaction both within some sites and between sites.

Members stated that staff did not have strong feelings of association with Gum Leaf and said that they did not have a good understanding of the organisational goals and priorities. People tended to think of their own site not the broader Gum Leaf organisation. The university team prepared newsletters throughout the project and encouraged feedback. These generated more angry and resentful responses from staff.

> *We have been short paid numerous times . . . it seems to be the tradition here to exclude the employee first and look after you at the same time*, *so yeah there's a lot of mistrust between employee levels and management here.* (Staff Member)

Why would we participate in this project when we have seen how people who speak up are [treated]? (Staff Member)

As the process continued, the SMT did not follow up on their tasks to develop a shared objective for HRM and to implement some of the identified opportunities to become an employer of choice. Planned events were cancelled and the project did not seem to be a priority.

In focusing on interventions to bring about improved people management practices, we suggested that as well as fixing the HRM policies, practices and processes, the organisation needed to consider the impact on staff and suggested that the next stage of the project needed to ascertain staff attitudes and how staff could be more engaged to bring about cultural change. The SMT were anxious about this process and were divided about how they believed staff would respond to opportunities to give voice to their feelings. However, the middle management members of the action group participated fully, providing practical suggestions as to how best to gather data on staff perceptions; interestingly, as we were seeing divergence in the SMT, we were beginning to see convergence of ideas within the middle managers in the action group.

We only see the senior managers when they perceive we have done something wrong . . . and when they come they don't talk directly to us. We feel like we could be a thousand miles away. (Staff Members)

In the subsequent year, workshops were held in which more than 70 staff participated. They were lively and exciting as staff identified current issues and possible solutions. At this point, over 12 months after the project began, the researchers were feeling positive. The State government department responsible for rural health care had received positive feedback about the project and the SMT were asked to present their story at a state-wide conference of rural health care providers. The Board appeared to be interested in the project and the organisation seemed to be taking ownership of some of the people management issues. Senior managers said that they felt more positive with a 'can do' attitude.

The university team, in focusing on structural and behavioural interventions, suggested a third component of the intervention: a leadership development program for middle managers, with an aim of engaging further with staff. Agreement was obtained, a program was developed, dates and times agreed and managers were approached to join the program. We visited all sites to inform managers of the aims of the leadership development program, the process to be used and the timelines. The managers rearranged their shifts to take part. Then, at the last moment, the CEO cancelled the program, claiming that it was too costly in staff time. At this stage, from the researchers' perspective, the change program slowly started to unravel. Despite the lack of consistent HRM being clearly identified by many investigations, the CEO was resistant to acquiring the HRM skills needed for the organisation. Instead, the CEO continued to rely on the HRM committee he had established and a part-time industrial relations consultant who was employed to manage the industrial relations bushfires.

Despite the CEO nominating first one and then subsequently another two senior staff members to act as the link between the university team and the organisation, the staff perceived that the regular 'management crises' at Gum Leaf took priority and there was never any time to plan action group meetings or activities: no one took responsibility. As a result, when we tried to embed the action group in the organisation as a form of employee consultation, nothing transpired and the group began to unwind. Meetings were cancelled, members stopped turning up and the action plan disintegrated. This may have been a result of the processes used in the action group meetings where the CEO acted to steer the discussion. Another important point was that the government department had been pleased by what they had seen of the project so far and had moved their gaze to other struggling agencies. Gum Leaf now became an organisation to be celebrated, not ridiculed. From the perspective of the CEO, the crisis was over.

Discussion

This project attempted to link researchers with the Board and staff, to work together capitalising on the combined strengths, to effectively manage needed cultural change in this organisation. The change process proceeded through several stages. The CEO lost interest as, in his view, 'success' was achieved. Referring to the faltering of the change process from our point of view, it was evident that change that threatens professional boundaries is resisted.[26] Strong silos existed between professional, functional and geographic boundaries, where key actors did not collaborate or act to bring about collaboration across silos. The CEO wrote in the annual report later that year that the OD project had been a success; he stated that there had been no industrial relations disputes that year, a major capital development had been completed successfully and the organisation had been nominated for a quality award. He had also agreed to appoint an HRM manager.

Key participants and identities

Community world

The Board of Management In many communities 'status coalitions' are formed among Board members, who tend to have some 'elite' status within the community. In this case, although the Board members were representative of the community, they had little knowledge of health sector management. Without knowledgeable medical staff on the board, there were no effective mechanisms to counteract the positional power of the CEO. As far as the Board was concerned, the new buildings and awards reinforced their belief in the CEO and garnered their support.

Other participants The influence of institutional participants was also apparent, with the Department of Health first pushing the intervention and then celebrating the achievements that had occurred. In addition, as noted above, the importance of the community response cannot be overlooked. Hence, the institutional context very heavily shaped the actions and responses of the decision makers in this project.

Control world

The CEO The role of the long-term CEO was instrumental in this change event, and in its cessation. The CEO's style, consistent with many hospital administrators of his tenure, was described as bureaucratic and transactional management: hierarchical supervision working through the chain of command and

using his positional power to pursue his vision for the organisation. It appeared that the CEO was energised by transactional and/or crisis management. His entrepreneurial activity was in obtaining funds for capital works and his preferred style was as an innovator with an external focus. And when capital funding and external recognition was gained, he regarded the project as successful. Being close to retirement, the CEO often stated that his legacy was the new buildings (and by inference, not the human aspects of the organisation).

The management teams The SMT was a mix of managers that had been at Gum Leaf for many years, with a couple of new arrivals. The restructure resulted in members of the SMT and the department heads that reported to them taking on responsibilities for which they were ill prepared.

Health services are a large component of the community and many of the managers and employees live in the local community. This means that they often have competing values between their community lives and their professional roles. Health professionals living and working in smaller communities may be more constrained in their workplace activities as a result of their higher visibility within the local community.[4] In this case, they did not want to 'rock the boat' within their very visible community lives through action at the health service or questioning the direction taken.

The SMT was consistent in their interviews about the deficiencies in HRM, but did not push an agenda for improvement as a team. At the time we felt that this was an extraordinary abdication of responsibility by these senior managers, but from the interviews it was clear that the SMT saw this as our responsibility. This was similar to MacLeod and Zimmer,[4] who found from their action research project that even though several improvement initiatives were identified by the participants, these participants did not want the responsibility of implementation, but rather wanted the researchers to take up their case with the perceived decision-making powers. At Gum Leaf there were divergent views about the role of the researchers: between their 'facilitation' role and their role as 'experts'.

The senior managers did not have a history of encouraging staff participation. Indeed, it appeared that they were threatened and panicked once staff were involved in the OD process. Their approach, with limited information sharing with staff, could be seen to be an effort (either conscious or subconscious) to maintain their authoritative domination (see also Ianello[28]). Instead of working with the staff to address the issues, the senior team retreated and created another boundary around them. This may have been due to their lack of confidence, skills and/or training as their roles expanded. For a successful change process, they needed to provide a support network for staff to draw on as an organisational coping resource. Many researchers (see Armstrong-Stassen[29]) have discussed the importance of supportive leadership during change events where managers show consideration of employee needs, increase communication and create a sense of purpose and excitement, as well as a can-do attitude towards the change. Employees also need to understand emotionally and intellectually why they have to change[30] and management must take the role in relaying this. However, when this project needed champions to come forward from the senior management group, the senior participants became invisible. This meant that an insider coalition to push the change agenda was not created and the barriers remained high between the senior management and staff.

Middle managers can make a positive contribution to change by facilitating communication between senior management and employees.[10] Lüscher and Lewis[7] argue that middle managers face challenges in sense making as top managers rely on them to span boundaries with lower levels while having fewer interactions with top executives. The result can often be debilitated decision making and implementation. We tried to lessen this by including departmental managers in the steering group. We found that although they were enthusiastic, the lack of action from the senior managers soon dampened the enthusiasm of the middle managers.

The relationship between middle and senior managers is important in getting managers involved with the change effort, in generating ideas and lowering resistance.[10] In this case, the middle managers were highly motivated and wanted to make the changes, but they did not see visible support from the senior team. In this organisation, most of the middle managers had a clinical background and could be seen to align more closely with the care staff rather than with the senior managers. The senior and middle managers did not have a history of participative partnership and worked in different 'worlds'. More work was needed by us in breaking down the barriers, in creating readiness and in gaining early wins.[24]

Care world

The staff Perhaps one of the key learnings from this project was the need to engage with all levels of staff. The early stages of the project focused on engagement of the Board and senior managers. Given the long distances between the various sites of Gum Leaf, the small numbers of staff within each of the facilities that constrained their release for development activities and shift rosters, there were limited opportunities to engage meaningfully with the Gum Leaf staff in the early stages of the project. The staff were looking to the CEO to change his talk and behaviour, which would have acted as a 'trigger point'[31] for staff to become more involved and empowered.

The employees were tired, their work had been disrupted over many years with the new building program, they had dealt with many crises and their high dependence on the use of emotional labour was taxing, causing frustration and resistance to change (see also Bryant and Wolfram Cox[32] and Bolton[33]). This may be because employees' perceptions are affected by the impact the change is perceived to have on their work,[8] and not phasing out old duties while assigning new ones, a culture of not being allowed to say 'no' to added duties and heavy workloads may hinder employees from getting involved in change efforts.

In times of rapid organisational change, where employees are faced with discontinuity and unpredictability, managers need to recognise that employees are likely to be highly emotional.[32] This is compounded in the health sector where extensive emotional labour is evident in nursing and more generally across other health professions.[33,34] Adding an organisational change process onto a workforce that has emotional labour at the very fundamental level of its work compounds problems in the change process.

Change that threatens health professional boundaries is likely to be resisted by employees, particularly by low status groups, and

therefore emphasising and negotiating new identities is important.[26] Healthcare employees prefer to identify with professional departments or groups rather than larger divisions or the macro-organisation. Membership in these larger groups threatens professional identity and contributes to a loss of individuality. It seems that healthcare change is threatened not just by the barriers between clinical and managerial workers, but by coalitions among those involved in healthcare governance (board members), management and caring (nursing and allied health) and curing staff (medical staff).[18]

Cure world

Medical staff Unfortunately, medical staff representation was missing from much of the OD process. As with many small rural hospitals, there was not a full-time medical director and the general practitioners who manned the emergency department and visited patients on the wards never considered themselves part of the staff and there was no expectation from the Board or CEO that they would give up their practice time to participate in the change project. This compromised the OD project, because it has been shown that involving doctors is a key factor for success of organisational improvement initiatives in hospitals.[35] The clinical coalition among the care and cure staff was only established at the bedside and remained far removed from the management, an identified weakness of health service organisations.[36]

Consultants/researchers

There were different expectations of our role among the staff, the senior managers and even among our own team. The staff had experienced many consultants, both employed by the organisation and imposed by others, and were rightly suspicious of this new group of consultants. As researchers, we sat outside the organisational confines and therefore were not readily embraced by the members of any of the professional groups. At one point the CEO suggested that we needed to be based at the hospital site for an extended period of time and although this was not practical, it may have assisted in building relationships throughout the workplace, with the CEO, SMT and staff. Maybe naïvely we saw it as the CEO abrogating his responsibilities, whereas he may have seen this as a way of strengthening our approach through being embedded rather than simply visiting.

Our main learning has been the importance of gaining an early understanding of the organisational 'worlds' and identities that exist in healthcare organisations, and ensuring that the OD initiative is planned and implemented to effectively bridge those worlds. In this case, in planning the initiative, the evaluation of the current state was explored by talking to the Board and senior team, but a view was not obtained from other stakeholders, such as the patients and other staff. Hence, important causal chains and linkages between managers, change agents, employees and staff were not ascertained to drive the interventions.[11] Given that a series of consultant reports had identified the same issues and recommended similar solutions, we fell into the trap of planning the intervention from the top, without ensuring the commitment and participation of the staff in the initial planning.

We failed to form relationships with staff and middle managers and the strength of our relationship with the hospital was at the Board, CEO and SMT. When we moved to forming and building leadership at these levels, the project faltered.

The CEO and SMT did not want the project to focus on negativities and hence possibly an appreciative inquiry approach[5] would have been more useful, shifting the emphasis from problem solving and conflict management to joint envisioning of the future, thereby providing support for the CEO and SMT in the change process. This would change the conversation to a new and constructive conversation or to a sense-making approach.[5,7] Lüscher and Lewis[7] call for collaborative methods to support sense making as interventions help actors to surface subconscious anxieties, cope with defences and alter their cognitive frames. Neilsen *et al.*[37] and Bennett and Durkin[38] argued that to achieve successful organisational change, effective management of the psychological transition of employees is vital, and that stress may lead employees to resist changes that they may otherwise support with patterns of dysfunctional behaviour. Such arguments are believed to be at odds to Lewin's[9] rational change process in arguing that change events are dominated more by power struggles than by rational decision making or consensus building.[39] We were aware of the struggles that the CEO and the senior team were facing, and a more focused agenda that fostered within-group and between-group trust may have had a positive impact. Similar to others[40] who have conducted research in healthcare, links were difficult to establish between groups, with line management based on budgetary discipline, as well as professional dominance and antagonism between professionals. Huzzard *et al.*[40] found that ultimately the key intervention practice was that of informal talk and conversations, with the researcher's role being to intervene through discourse at boundaries. Our approach of meetings and workshops may not have been the best course of action in these circumstances. In addition, the geographic distance between the researchers and the sites meant that long periods of times elapsed between formal visits, rendering informal discourse with those different groups across all sites and professional groupings difficult.

Conclusion

The analysis of this OD initiative illustrates the aspects of public healthcare organisations that increase organisational resistance to change. Success is difficult to judge; for instance, the CEO judged the project as a success but for us it was more problematic in terms of whether the people management practices, including systems, processes, policies, attitudes and behaviours, improved and created an innovative and effective organisational culture. For other participants, success could be seen through upgrading of facilities and physical working conditions, as well as processes introduced to ensure adverse events did not occur. For others, such as directors and the SMT, from their perspective success may have been achieved as they progressively learned to work together and take on the extra responsibilities of their newly created roles.

The existence of at least four different organisational 'worlds' and identities, according to different professional groupings with different goals, different languages and values, and different approaches to the business of health care were evident. Although some important gains were made, and from the perspective of the CEO and board of management success was achieved, more could have been achieved from our perspective. Similar to Cooney and

Sewell,[41] from a political perspective 'managers sought the credit for the successful aspects of the change program but were unwilling to accept full responsibility for the failures' while successfully neutralising the 'others' and their perspectives. Moreover, as Glouberman and Mintzberg[18] state, there is evidence in this case of how people in hospitals seem to prefer urgent situations because urgency provides a sense of shared purpose that is often absent during routine work. But once the urgency passes, the usual fragmentation sets in again.

There was a lack of momentum and management motivation at upper levels throughout the process and the restraining forces were just too great: uncertainty, fear of the unknown, threats to security and position power, redistribution of power and influence and conformity to norms and culture. Power resided with the containment coalition rather than the clinical coalition. It is clear from this work that when thinking about the order of interventions, change is not linear and it is important to review and to ensure all participants' views are included at each key phase. An understanding of the emotional and political nature of change is essential in framing any OD intervention. The relationship between the researcher and subjects is key in terms of whether the researcher is seen as an 'expert' or as a 'facilitator'. Our relationship tended to focus on the upper echelons of the hierarchy and more work should have been done on forging stronger relationships with all levels. The middle managers and staff should have been included and empowered from the beginning, with internal change agents being encouraged to develop so that they took responsibility rather than see it as the researchers' role. In bringing about change, we needed to work with the CEO in empowering others. Hence, the researchers need to engage in continual dialogue across boundaries and within groups as well as at individual levels to provide support for organisational change.

Competing interests

None declared.

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