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Organizational Reconfiguration in Health Care: A Life and Death Struggle

Introduction

On April 1 2008, three acute hospital trusts in a rural part of the United Kingdom merged. Despite an abundance of available evidence that mergers rarely accomplish stated goals, and that they reap unintended consequences which cause profound and irrevocable disruption (Fulop et al 2002, Kitchener 2004), the restructuring went ahead. Notwithstanding volumes of evidence available on the appropriate management of change, (Kotter 1995a; Bridges 1996;) about the importance of transparency, timeliness, the flow of information and communication channels, the new organization was born with only one of several statutorily required players in place, an interim chair.. Serving a widely scattered population of 382,000 people, with a budget of £322,000,000, five months into its life, the new organization was still operating without the usual personnel, structures, and processes in place. Instead, the three former executive and management teams were stripped of their authority but directed to stay in place and carry on ‘business as usual’ for a period of time as yet undetermined.

As chair of one of the merging organizations I watched and participated in the reorganization juggernaut with an apparent lack of voice and power. Subsequently my former non-executive director colleagues and I wrote a critique of the process using the media to publicize it widely. Government officials were forced to take note and agreed to investigate. At an initial fact finding meeting with the senior civil

servant in charge of the investigation, he lamented, ‘why don’t we learn from our past?’

My question echoes his, ‘why don’t we learn from the evidence available to us? Instead, we have witnessed and participated in unnecessary and unacceptable suffering and humiliation, as leaders and managers were stripped of their status and authority and left in limbo. The organizations they led were left adrift in a sea of uncertainty and rumour.

Many have written eloquently on topics such as the brutality of organizational reconfiguration couched in euphemism, (Allcorn et al, 1996; Stein, 2001), the loss of effectiveness (LOE) resulting from even partial change in organizations (Grady and Grady, 2008), the use of role objects in coping with transition. (Mersky, 2008). These valuable contributions foreground actions and reactions in the face of change.

This paper takes steps in a slightly different direction, foregrounding the ‘givenness’ of change, examining the seeds of repetition underpinned by the question: Why do these change processes continue to be so messy and so brutal? More fundamentally, especially in health care, why do we perpetuate the cycle of continuous large scale unproductive change?

The paper reviews relevant concepts from organization studies, leadership studies and the psychodynamic literature to accomplish three things:

- 1) to develop a compelling cross disciplinary language; and
- 2) to create an explanatory framework that addresses the continuing mis-creation and mismanagement of organizational change in the NHS;
- 3) to reconsider intervention processes that might be most effective.

Each of these related disciplines offers a layer of insight so when they are synthesised they provide a broader and deeper account than each could offer individually.

Approach

The development of the paper relied on an autoethnographic approach, (Holt 2003, Anderson, 2006) as I was an insider at the time of data collection. A series of ‘snapshots’ throughout the paper build on personal diary entries, discussions with key players and public documents. These contribute additional evidence to support the views of others (Weick and Sutcliffe, 2003; Obholzer 1994, Czander, 1993) that there are features about the health service in this specific context that makes it particularly susceptible to the problems described here.

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Snapshots through three different lenses, those of organization studies, leadership and psychodynamics each in turn illuminate facets of the situation that address the question: ‘why don’t we learn from our evidence and experience?’ Table 1 identifies some of the key themes to emerge from each domain and serves as a road map to the exploration.

Table 1 (*Insert here*)

A brief review of some relevant concepts in the organizational studies literature helps to set the organizational context raised in the question: ‘why don’t we learn?’ and comes next

Organization Studies Lens

Denyer et al (2008), Pawson (2002), Pfeffer and Fong (2005) each in their own way locate the problem ‘Why don’t we learn?’ partly in the research community itself and the massive amount of evidence that is complex and often contradictory. Nevertheless three concepts emerge that are useful in addressing the question. They include: the conceptualising of the NHS as a high reliable organization, the phenomenon of naming and shaming and the tendency to self-enhancement.

Is the NHS a High Reliable Organization Under Threat?

Denyer et al (2008) referring to the work of Gaba (2000) identify health care as a high reliable organization one that repeatedly perform activities with high hazard technologies but experiences very few errors and incidents. High Reliable Organizations live in a context in which there is high social and political pressure not to fail. They experience interactive complexity, with the potential for interacting systems to serve incompatible functions: for example, in the NHS policy makers set targets for clinical performance, while the targets they set for financial solvency have the potential to diminish clinical performance. The key job facing NHS managers is to juggle and fulfil these two priorities. Reorganization is often used in health care across the world as an intervention or magic bullet to fulfil competing priorities.

Denyer et al underline the importance of interrogating hypotheses such as the effectiveness of organizational change. The interrogation should determine how the intervention might achieve the desired outcome.

In the case of the merger in question, that interrogation into the underpinning hypotheses occurred early in the process

Snapshot one

Members of the staff, community, and I were sceptical about the shallow arguments presented for merger. I asked for a costs/benefits analysis prior to agreeing the merger. The response from the CEO's, civil servants and other trust chairs who sat on the project board preparing a case for the merger were as following:

- *We don't have time to go into this detail*
- *The government wants to 'rationalise'*
- *We can't keep going the way we are financially and clinically*
- *So and so down the road merged and it worked out ok.*

The snapshot gives a brief glimpse into the relentless and powerful resistance to any interrogation of outcomes when the decision had already been made based on questionable assumptions.

Reliable operations in High Reliable Organizations require oversight of appropriate 'actors' who can conceptualise problems and evaluate potential options through a process of sense-making. Attention, alertness enhanced by mindfulness, unambiguous real time information about the health of the system are key to reliability. Heedful interrelating amongst these actors that includes trust, respect, and honesty is vitally important. (Weick and Roberts,1993).

Weick and Sutcliffe (2001) note:

‘With every problem, someone, somewhere sees it coming. But those people tend to be low rank, invisible, unauthorized, reluctant to speak up.’ (p. 74)

The following brief snapshot paints a picture of some of the organizational climate in which people are reluctant to speak up.

Snapshot 2

Prior to the minister of health’s announcement of the go-ahead for merger, but after the individual merging boards had submitted their recommendations, the whole health community of this region held its breath awaiting a response from the minister. A regularly scheduled meeting took place between her and trust chairs from across the country. I was unable to attend and sent another non-executive director in my place. He reported back that during the meeting, he asked about progress toward a decision about the merger. The minister scowled, turned away and said: *‘How dare you give me caveats,’* referring to the list of recommendations that accompanied the board’s approval of the merger. She then turned back, smiled and said: *‘But I might choose to be generous.’* I was concerned for my colleague in the face of this public treatment and outraged by what I perceived to be blatant abuse or at least unhelpful behaviour. A longstanding local politician, he shrugged the event off, saying he was used to it.

There was a reluctance in many key players to speak up about their concerns, given the absence of heedfulness amongst key decision makers.

Naming and shaming works - sometimes.

Pawson (2002) acknowledges the endemic nature of naming and shaming in public services. In making public a critique of the merger process, my colleagues and I got immediate results, a new grant for the smallest hospital and the appointment of some key personnel. The fact that naming and shaming is perhaps the only effective means of getting immediate results makes a strong statement about the culture of the organization and the society in which it sits. The current government is particularly sensitive to public disclosure via the media, outright fear constantly lurking in the wings and elaborate precautions against 'leaks' part of the modus operandi in the day to day work in management and leadership in the NHS in this small country.

There is not a crime, there is not a dodge, there is not a trick, there is not a swindle, there is not a vice, which does not live by secrecy. Get these things out in the open, describe them, attack them, ridicule them in the press, and sooner or later, public opinion will sweep them away. (Pulitzer, 1978, quoted in Fisse and Braithwaite, 1983, p. 1)

The secrecy and the corruption that sits behind it will be discussed more fully in the psychodynamic section of this paper.

Naming and shaming can get results and paradoxically it also leads to hiding. The tendency to self enhance (Pfeffer and Fong 2005), that is to see oneself in a favourable light, explains how naming and shaming, in an accountability focused

culture such as the NHS prevents a constructive criticism or the useful evaluation of outcomes. The self enhancement tendency fuels cultural entrapment.

Cultural Entrapment

The Weick and Sutcliffe (2003) re-analysis of the Bristol Royal Infirmary inquiry exposes many parallels to the merger under review here.

They identify a process of ‘cultural entrapment’, underpinned by escalating behavioural commitment (Salancik and Pfeffer, 1978), in which people get locked into a particular course of action, because their decisions are 1) important, 2) visible, 3) hard to undo, 4) highly volitional, that is, those making the decisions have high levels of choice. Ironically, as Weick and Sutcliffe (2003) point out, high levels of choice militate against learning. Reputations are on the line and decision makers continue to justify their actions by selectively screening the environment for socially acceptable confirmation, ignoring important clues that contradict the course of action. The clinical, managerial and geographic rationale given for centralization and the establishment of the Bristol Royal Infirmary thirty years ago are identical to the reasons given for the merger under discussion. Emphasising the importance of challenging easy explanations with shallow plausibility, the dangerous person in a scenario of escalating commitment and cultural entrapment is an exposed individual whose vulnerability diminishes only when they find justification with increased plausibility, thus hardening the justification into dogma.

The following snapshot steps back into the process prior to the merger to provide an example of how commitment escalates and hardens

Snapshot 3

The project board overseeing the merger process submitted the proposal for merger to the government in October 2007. In the hands of a government health minister with a reputation for micromanagement there was an unexpected and unexplained delay in response. The timing now was precarious as it was unlikely that it would be possible to put a new organization in place before the April 1st deadline.

On December 3rd, the chairs of the three hospital trusts each received a letter from the minister of health informing us that, while she was considering our recommendations, she could offer no promises that they would be fulfilled. She asked us whether we wanted to reconsider our decision to merge. She wanted a response within three days. Our whole agreement to the merger hinged on an acceptance of the recommendations we believed to be pivotal to the future success of the merged organization. However the response from the same executive teams and the project board who made the original recommendations were the following:

“Nothing has changed (really)”

“We’ve gone too far down the road”

“We aren’t clinically and financially viable.”

“We can’t drag this uncertainty on another year.”

The continuing justification, from the CEOs, executives and other project board members, was sustainability of service. What could be a more socially appropriate justification? By now merger had become the ‘given proxy’ for protecting and enhancing patient services. The system had long gone past any examination of the equation : merger = sustainability.

Executive level reactions to staff and public dissent were paternalistic.

They don't understand.

They don't realise this will be best for them in the long run.

They'll forget about it soon and it will all go away.

What the snapshot demonstrates is a whole system in collusion. The individuals, in executive and management posts had vested interests at stake in showing solidarity and dogmatic commitment to a process that could never be delivered at this late stage in a responsible way. The CEO had been promised the top job if she could successfully pull off the merger. Other members of the team knew their future careers were in the balance.

The story moves now from a discussion focusing on the organizational context to a larger environmental and social context in an attempt to understand these influences on leadership behaviours and actions.

The Leadership Lens

Kakabadse et al., (2003) note the paucity of leadership in government in three different countries. In describing the current ambiguous context in public services they refer to the observations of Walsh (1993)

“The entanglement of political strategies from the government of the day with the machinery of government has thrown into question the political independence and integrity of the public sector. This politicization has gradually seeped down the ranks of the public sector, with officers being confused about who they are answerable to-

their political masters of the day or the wider concept of community. Accountability, the buzz word of the past decade of reforms, has given rise to the question- accountable to whom?" (.p.479)

This confusion is the result of unresolved conflict in minister-civil servant relationships.

The following snapshot illustrates the ambiguity of accountability.

Snapshot 4

Subsequent to my various challenges to my colleagues on the project board, the 'independent chair' appointed by the current political figures took me aside.

He said: In your mind who do you think you are accountable to?

I said: Ultimately, to the community.

He said: Your accountability is solely to the minister.

I said: Is she not accountable to the community?

He said: You're accountable through her.

In other words, in his mind I had no direct accountability to the local community for the actions that I represented but was a mouthpiece for the political party of the day. I had been appointed by the previous minister through the public appointments process, at which time he described himself and his party as but one of the many stakeholders whose views and wishes I should consider in safeguarding the health services of the local community.

The domain of leadership studies examines the phenomenon of leadership in a wider societal, philosophical and ethical context, considering what is, against an aspirational vision of what leadership ought to be. Ethics is a critical aspect of leadership because it provides a set of principles through which leadership can examine the interplay between morality - what is good behaviour, and values - current beliefs about what is desirable. The function of leadership is to lead through the increasingly complex maze of values conflicts and paradigm shifts in ethical frameworks.

The context that Kakabadse and Kakabadse (2003) describe is one that has moved from utilitarian ethics with a values orientation of community benefits to a personal competence morality with a value-orientation of individual benefits. This shift has signalled profound change. There has been, in the central public policy objective, a change in emphasis from the 'social good' to the 'economic good'. (Cerney, 1990). The public sector's role has moved from the delivery of public services to the management of scarce resources. Public sector leaders and managers have adopted a financial bottom line mentality, of which they are often unaware. Coupled with the traditional political bottom line mentality, decisions that favour short term solutions are taken regardless of the impact on others or the long term health of the organization.

Moreover, large organizations introduce the problematic issue of proximity—the physical and emotional distance from the decision maker to the person or thing that receives the final impact of the decision. By the time the decision reaches its destination, the impact is often tragic. (Wolfe, 1991)

When humans act individually in their environment, their nervous systems, their whole range of sensing abilities (including their conscience) are

invoked. Usually they see and feel the impact of their own actions. They act as integrated individuals. Somehow we must address this problem of proximity (p. 427)

These two contextual issues, the shift from a utilitarian ethic to a market mentality and the issue of leader proximity, were the two most frequently regretted by those who grappled with the various decisions that made up the merger process.

Ironically, the minister of health of the day has made the abolishment of the ‘internal market’, a symbol of bottom line mentality, her call sign. However, the minister and her decision making colleagues have co-opted reorganization and reconfiguration, tactical hallmarks of a market mentality, to resolve the perceived financial and clinical inefficiencies of an ailing service.

Wolfe (1991) observes that western society lives on the cusp of a seismic shift, from a system and set of values built on the individualistic paradigm of the enlightenment, where the individual had some perceived control, to a society that lives in the shadow of organization, (Denhardt 1981). People make decisions and take actions as organizational people that they would never take as individuals (Bakan 2004).

Organizations have replaced communities. To step outside a paradigm in which everyone is caught requires a conscious effort to examine the ways in which the age of organization within the prevailing economic mindset of capitalism compromises and corrupts our perceptions and actions: this is the job of ethical leadership.

Grojean et al (2004) discuss the critical role of leaders in establishing expectations regarding ethical conduct. In the early period of an organization’s development, the personal values of the founder and other early leaders become embedded through primary mechanisms such as criteria for rewards and resource allocation, and

secondary mechanisms such as structure, rituals, mission statements. The context and the ethos of the founders of the NHS, were service-oriented rather than market-oriented. The abiding organizational values, coupled with the professional values of those who provide health services, are still cure, care, service and to some extent sacrifice, although this last feature has been eroded. The collision of the traditional street fighter culture of politicians, (watch the horror of a parliamentary session), with this ethos of life-sustaining service has been the source of a deep sense of betrayal. The collision of espoused values (we care for people) and values in action (we care for people, but not staff) gives rise to profound bitterness.

Grojean (2004) drawing on the work of Bandura (1986) concludes: Leaders who demonstrate actions that are consistent with the organization's values and mission are likely to be viewed as more trustworthy. (p.229) As Weick and Roberts (1993) pointed out, trustworthiness and heedfulness are associated, and both are required for the functioning of high reliable, high hazard organizations such as the NHS.

Kakabadse and Kakabadse (1999) are in agreement, reporting that effective leadership requires the capacity for quality dialogue, vision, discipline and cabinet responsibility, characteristics which rest on maturity, forthright discussion, listening and feedback. However, their comparative study across three countries reveals a paucity in the UK government in the first two dimensions (Kakabadse et al., 2003). In public services in the United Kingdom there is a serious lack of vision and poor quality dialogue. There is little agreement on what to lead and how to lead, that is, on the process and content of leadership.

Rost (1991) also distinguishes between the process and content in a discussion of ethics and leadership. He lifts the leadership discussion out of a paternalistic emphasis on leader qualities and characteristics to introduce a notion of post-

industrial leadership, as a mutual influence process that occurs between leaders and followers who together ‘do leadership.’ What binds the players together is a mutual purpose to effect real change. However, the ways in which leaders and followers interact, using power and authority, will determine whether the process is ethical and indeed whether the process can be characterised as leadership. A pattern of relationships that is predominantly authoritarian and coercive is not leadership, in that coercion and authoritarian demands are neither mutual nor influential. Using the criteria of choice to define the parameters of influence, Rost carefully strips away coercive behaviours from the leadership equation, identifying those actions that deprive players of a choice: actions that command obedience in the name of some legitimate authority; actions that include the threat of consequences if one does not behave in prescribed ways; actions that intend psychological intimidation. While acknowledging the difficulty of arriving at absolute answers, he offers the following question as guidance:

“How much room do commands, threats and intimidation leave for people in the relationship to freely agree that the proposed changes fairly reflect the mutual purposes of followers and leaders?” (p. 162).

The merger process exposed and exacerbated a coercive authoritarian culture that encouraged passivity and harboured such fear and chronic attitudes of vigilance and suspicion, that I was reminded of the book *The Whisperers* (Figs, 2007), describing everyday life in Russia during Stalinist times, where communication could only take place in whispers. This sort of domination/subordination culture did not happen overnight. Second guessing the motivations, intentions and movements of a current government, reading the runes is part of daily business in upper management in the

NHS. As Miller (1986) points out, those in subordinate positions know more about those in dominant positions than the other way around..

While great concerns were expressed about the way the current minister of health was developing a track record for inappropriate interference, unpredictable behaviour and disrespect, when I asked what stopped people from making their views known, the responses were variable:

We have mortgages to pay

She has sidelined people with long standing careers in the civil service who are in a state of shell shock

She is barking mad

When I expressed my concerns to the representative of the national watch dog body and asked for his opinion about whom I should approach and where were the checks and balances in the system, he cautioned me:

You realise if you go public with this, you will never work in this country again.

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Wolfe (1991) notes that large organizations need cogs in the wheel, who have been institutionalised into 'corporate thinking', can be moved around at will, and who have internalised authority structures. Referring to the Milgram (1974) experiments, he concludes that people behave differently in large organizations than they would as independent individuals and they seldom have the moral strength to resist authority.

While the intentions (content) of the leaders may well be noble, seeking to improve services to patients, their methods (process) capitalize upon a culture that provides a paved road to totalitarianism.

Rost (1991) and Wolfe (1991) are among many who acknowledge that it is who we are, as much as what we do, that determines ethical leadership. Wolfe goes so far as to suggest that preparing people as managers and leaders should be built upon the study of what Jung (1959) calls individuation; that is getting to know and embrace our uniqueness as human beings which would allow us to separate ourselves, to stand apart from social institutions, as humane, thoughtful, action-oriented beings. This would demand a significant level of self-examination and self-understanding of intrapersonal dynamics, those unconscious forces that continually shape our actions and the relationship between these and interpersonal and systems dynamics.

The final section examines the dynamics of the intrapersonal and the system as the engine that drives phenomena such as escalating commitment, self-enhancement, coercive and ineffectual leadership, all resulting in irrevocable human costs.

The Psychodynamic Lens

Corruption in the service of the quest for the best

Corruption in the quest for ultimate narcissistic fulfilment (Levine 2005) is at the heart of the rise and fall of many great organizations that are captivated by the notion that they are unique and special. It seems that leadership in the NHS may be, or may become, particularly susceptible to the mindsets that lead to corruption and to the secrets and deceit that inevitably accompany corruption.

Corruption includes an essential element – an effort to hide an unfavourable, unacceptable reality... Corruption is intimately involved with secrets and with the deception needed to protect a reality hidden as much from the corrupt as from their victims. (Levine, 2005: 728)

It may be that the noble ideology of the NHS is no longer achievable. But to face head on the fact that the largest organization in Europe, the one that serves as a bulwark in our collective denial of death (Becker 1973), is very sick and likely to be dying is unthinkable. With leaders who treat the organization as their property, with deep narcissistic needs to be seen as good, lines are crossed. For example, there is a fine line between independent-minded intelligence, the ability to circumvent outdated norms, structures, and behaviours that disregard with arrogance and contempt normal and even legal constraints.

Snapshot 5

In the United Kingdom, hospital trusts are legal entities. At the point of establishment, their existence becomes legal through ‘establishment orders.’ The legality of their existence hinges in part on governance arrangements, the normal arrangements being a board of directors consisting of a chair, executive and non executive directors. The CEO of a hospital trust is the designated ‘accountable officer’, responsible for all that happens within the organization. In addition, in a merger and transition of this size, it is proper practice to ensure that there is up to a year, but at least a minimum of six months, in which a shadow board consisting of

new board members works alongside the existing boards of the merging organizations, in order to facilitate a smooth transition.

The new hospital trust came into existence with an interim chair in place and one non- executive director appointed just days before its establishment. At least one CEO had to ask who would be the accountable officer for the new organization, to whom she would hand over her current accountability, in view of the fact that she was demoted from accountable officer status.

The critique has queried whether the new organization was established and worked for several weeks from its inception ‘ultra vires’, that is, beyond the law. The investigation into this matter is still underway.

If not beyond the law, the decisions taken during this time were certainly sailing close to the wind. Leadership appears to be anxious to demonstrate what can be accomplished when burdensome regulations are sidestepped. Levine (2005) also notes that the corrupt organization is a likely site for sadistic behaviour, discrediting others to make oneself appear more worthy, and cites the experiences at Enron where trusted employees were told they were failures, stripped of their titles, shunted around; all actions that mirror those in the current merger.

Czander (1993) has more to say about the mix of narcissism and sadistic behaviours, noting that narcissists often appear at first to be benevolent leaders, but harbour rage, anger and resentment under the surface.

‘This leader uses subtle rage and derives great pleasure and gratification from damaging others....These leaders demonstrate a considerable amount of insensitivity

and lack of awareness of the pathological human relations they foster around themselves. (p. 287)

They debilitate others, especially subordinates because there is no give and take, no mutual identification in their interactions with others. The current leader reflects an anti-managerial zeitgeist and has made known publicly her distaste for management - the people and the process. When questioned in a meeting by a person in a management role about the potential ramifications of reconfiguration on management, the leader's response was:

“I am not concerned at all about you lot who earn over £30,000 a year. You can take care of yourselves.”

This same leader prohibits minutes of meetings she holds with management and leaders in the NHS - ‘in order that they can have a frank and full discussion.’

Thus there is no one to comment, to bear witness, or to serve as check and balance.

Anzieu (1984) using dramatic metaphors that revolve around the group as a body, particularly poignant in the context of the health service, accounts for the phenomenon of frozen group silence. Because of unconscious fantasies projected onto the group such as ‘they will eat me alive’, no one in the group is willing to say anything.

Obholzer (1994) echoing Becker (1973) notes that the NHS serves as a container for social anxiety about death and dying. There is a necessity that all parts of the health service system remain in dialogue about the nature and difficulties of the primary task. Both he and Czander (1993) comment on the increasing split between leadership, management and the technological or clinical work whereby managers can turn a blind eye to the consequences of their decisions, while the clinical people,

and the general public can continue in their collective fantasy that, with unlimited resources, eternal life would be available to us all. A refrain amongst the workers in the smallest of the merged organizations over a number of years, where senior managers could have been physically visible, has been the invisibility of senior management. So managers become the repository for blame about the failures of the system.

Under siege

Czander (1993) illuminates too the apparently differential treatment this part of the country received regarding the merger process. While mergers in other regions of the country were permitted to be carried out 'in house' amongst the merging organizations, this merger was treated differently by the politicians who set it up. The differences included the appointment of an independent chair and director of the merger project board, the inexplicable delays in establishing a fully functioning organization and the particularly brutal treatment of senior management. He suggests that the larger system unconsciously attempts to keep the sub-system dysfunctional, using it as a scapegoat to blame for all the failures of the larger system. However, support is given to those parts of the system that can add prestige.

The nature of the merger context, a rural farming area with an ageing population, means that a greater proportion of the health service is devoted to caring rather than curing. The prevailing attitude amongst external decision-makers was summed up in a comment made to me by the most influential CEO in the country, who heads up the largest NHS organization in the urban south of the country:

You lot up there should be closed down. If somebody came in with an aortic aneurysm they would die. Down here they could be saved. Why should we down here pay more taxes to keep you going? You can send everyone down here.

Care should be sacrificed for cure.

Stein's (2001) analogy of corporate cleansing to ethnic cleansing 'which views the survival of the whole depending on the expulsion of unwanted parts.' (p. 69) seems apt here. It fits in neatly with the refrain throughout this period:

They seem to have set us up to fail.

In addition, in a country newly emerging as a self-governing entity, with the south becoming an urban, affluent area, this quirky, if feisty backwater, is a reminder of the poverty, perceived powerlessness and oppression of the recent past, which there is a desire to disown and to make disappear.

Groups and organizations free up aggression. Anzieu (1984). There is an ambivalent relationship, both fear and awe, with a leader who acts out collective aggressive impulses, takes charge, dares to break the rules, has made a stupendous number of large allocations in a short time to shore up the NHS, drawing on the resources of the future, self enhancement theory in action.

A very brief dip into psychodynamic perspectives suggests that the National Health Service, as one of society's greatest defences against death and dying serves as a container for the deepest anxieties. It may be particularly vulnerable to attracting narcissistic leaders with deep needs to separate bad from good and to align themselves

with the good. What could be more powerful in the quest for ultimate narcissistic fulfilment than to vanquish, or appear to vanquish, death? Narcissism often comes coupled with sadistic tendencies. With the implicit permission of a bottom line mind set, ostensibly in the service of the common good, no one is good enough, every person and every organization is potentially redundant and expendable, and is to be aggressively punished for failing to provide certain immortality.

Discussion

Explanations on the road to remedy: What's the story?

Snapshots through three different lenses, those of organization studies, leadership and ethics, and psychodynamics have each yielded a number of themes (see Table 1) in attempting to answer the question 'why don't we learn from our evidence and experience?' One emerging theme across the three theoretical contexts is that 'the solution is the problem.'

One of the problems highlighted in *organization studies* is the proliferation of research. Nevertheless several concepts do emerge and contribute to the conversation. The NHS is a high reliable organization that deals daily with high hazard work. It is under constant public scrutiny and pressure to perform. Reorganization and reconfiguration are traditional attempts to reform performance. The whole system is the victim of cultural entrapment in which key players escalate their commitment to their decisions, through rationalisations and plausible justifications in a continuing effort to self-enhance. Other players in the system are unwilling or unable to make

their voices heard, either because they see themselves as beneficiaries from the perceived glory promoted by self enhancers, or because of structural obscurity, that is, their position in the structure gives them little or no authority.

Studies of leadership and ethics contribute to the conversation by offering a critique of current social arrangements, underpinned by an ethical shift from the social good to the economic good, fostered by the emergence of large organizations. Exacerbated by increasing role ambiguity between politicians and civil servants, the public service, including and perhaps especially the health service, is increasingly politicized, and accountabilities have become questioned and questionable. In the absence of a consciously articulated ethical framework, those in leadership positions cannot agree on what to lead and how. In addition, leadership as it ought to be in a democratic post industrial world, a mutual influence relationship amongst leaders and followers, is all too often corrupted by coercion and the abuse of power and authority, resulting in an organization that has become increasingly totalitarian.

Psychodynamic studies of organizations, in particular those of health care, reveal the deepest drivers underpinning current arrangements and patterns of behaviour: fear and denial of death. Bringing the individual to the conversation, the psychodynamic literature highlights the significance of unconscious intrapersonal phenomena such as narcissism and how the mechanisms of splitting, projection, fantasy are mirrored in the organizational world. At an individual and intra-psychic level, members of the current society experience grave and unconscious fear of death. At a systemic level, a whole ethic and mind set of capitalism and the economic good has been constructed to deny death. Leadership in the public health service, as in any large organization, uses the perceived immortality of the organization as a bulwark against individual mortality. The NHS, which is now in the business of ensuring immortality, is

particularly vulnerable as it reaches the limits of its capabilities to fulfil its promises. Leadership, often with deep narcissistic needs which may be a more pronounced fear of death, makes ever-increasing superstitious manoeuvres, such as reconfiguration and reorganization, to stave off the demise. Driven by the need to self-enhance, to be worthwhile, to look good, decision makers, who in current structures have most choice, justify and rationalize actions, escalating and dogmatizing commitment. The whole system is so distracted by the intensity of change and the vulnerabilities induced that the cycle continues in perpetuity.

Figure 1 (*Insert here*)

There is immense complexity here and opportunities for intervention at many different levels. These include the intrapersonal: addressing individuation; the organizational: addressing cultural entrapment; and the societal: addressing shifting ethical frameworks

Conclusion

This paper attempts to provide a greater understanding, in the context of a recent merger, to the question: *why we don't learn from experience?* Instead we re-create endlessly organizational circumstances in health care, at great cost, that don't work and cause great pain.

It's important to divert for a moment to comment on the proliferation of research, and the resulting complexity and fragmentation such that it becomes difficult to find a coherent story. Thus the body of knowledge falls apart as it becomes increasingly meaningless. This phenomenon mirrors the condition of the health service, where the exponential demands and expansion are such that the body is falling apart under its own impossible weight. It requires vigilance and on-going effort to discern patterns in order to make sense of the story.

The use of metaphor is a way to capture patterns and convey them persuasively. Stein (in Allcorn et al 1996, Stein, 2001) uses startling metaphors such as 'holocaust', 'ethnic cleansing' to give voice to the experiences of those who are caught in the crush of manufactured change. An on-going commitment to telling the truth, in language that jolts the attention, is fundamental to intervention.

Framing the actions described here and in so many other places as ethical violations may also capture attention. I suspect it would be a surprise to the various players in the health care system, leaders, staff, patients, the general public, to realise that those violations which are taken for granted and tolerated, should actually be regarded as ethical violations.

Wolfe (1991) has outlined a whole curriculum for the study of ethics in business. He states clearly that an ethics curriculum should not be a study of the old philosophers of ethics, taught by those already institutionalized in the 'system'. The cornerstone of the new curriculum is the study of the process of individuation, becoming fully and uniquely oneself. Given the direction this paper has taken, a study of individuation would include the opportunity, in a supported environment, to confront our own fears of death and the mechanisms - intrapersonal, interpersonal and systemic - that we use to deny our mortality. Stein (1996) has addressed the need to support victims of

organizational change in mourning. Mourning is needed on a much wider scale as we let go of that current central illusion: limitless hope. We may then be in a position to be open to each other in truly addressing the common good.

Rost (1991), an American writer, called for the development of a new vocabulary of civic virtue, absent in the current culture of individualism. It can be said that the United Kingdom does indeed have a language of civic virtue. Too often, however, it has been co-opted into the service of the bottom line. Each of us must develop the capacity to discern that essential difference between the common good and the bottom line.

At the heart of the discussion here is the view that accepted practices need to be reframed as unethical and then challenged as such, but also a more interactive participatory process of change management is needed.

- There is a need for well informed, credible ‘free floaters’, concerned citizens who act as border pilots cruising the interface between the inside and the outside of organizations.
- Free floaters ideally challenge at a people at a pace they can stand.
- They catalyse ‘small resistances’. (Amado, 2008)

Foster (1989) elaborates this critical view of leadership:

It is an enduring feature of human life to search for community; to attempt to establish patterns of living based on mutual need and affection, development and protection. ..

Certain agents can engage in transformative practices which change social structures and forms of community, and it is this we label leadership. But for leadership to exist in this capacity requires that it be critical of current social arrangements and that this critique be aimed at more emancipatory types of relationships;...

Leadership then is not a function of position but rather represents a conjunction of ideas where leadership is shared and transferred between leaders and followers, each only a temporary designation. Indeed history will identify an individual as the leader, but in reality the job is one in which various members of the community contribute. Leaderships and followers become interchangeable. (pp. 48-49)

We all have a part to play in a relationship that can lead the National Health Service to successfully and humanely reinvent itself.

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Figure 1 - Governance in Acute Trusts in the British National Health Service

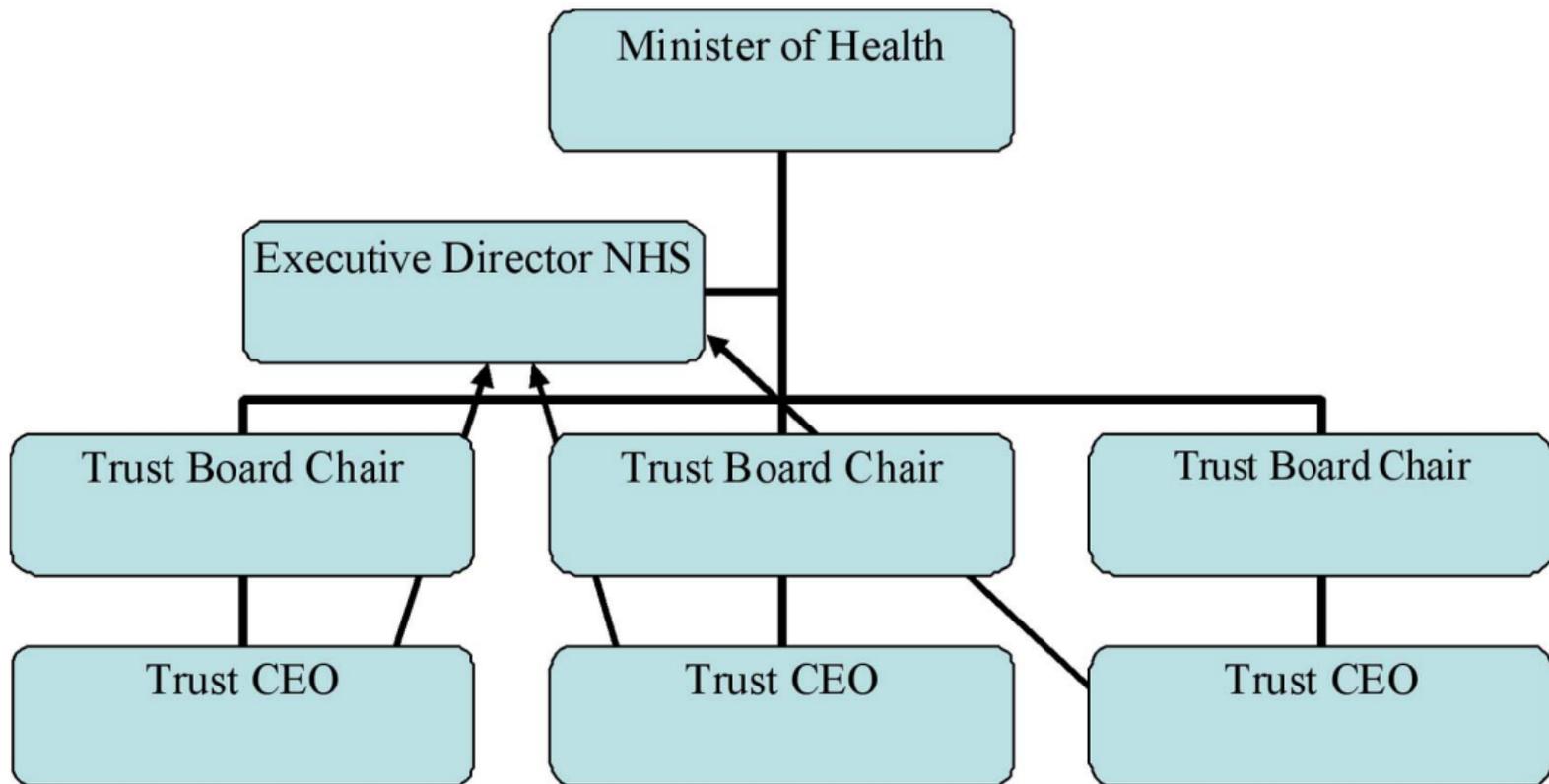


Figure 2 – Governance of Trust Merger Project Board

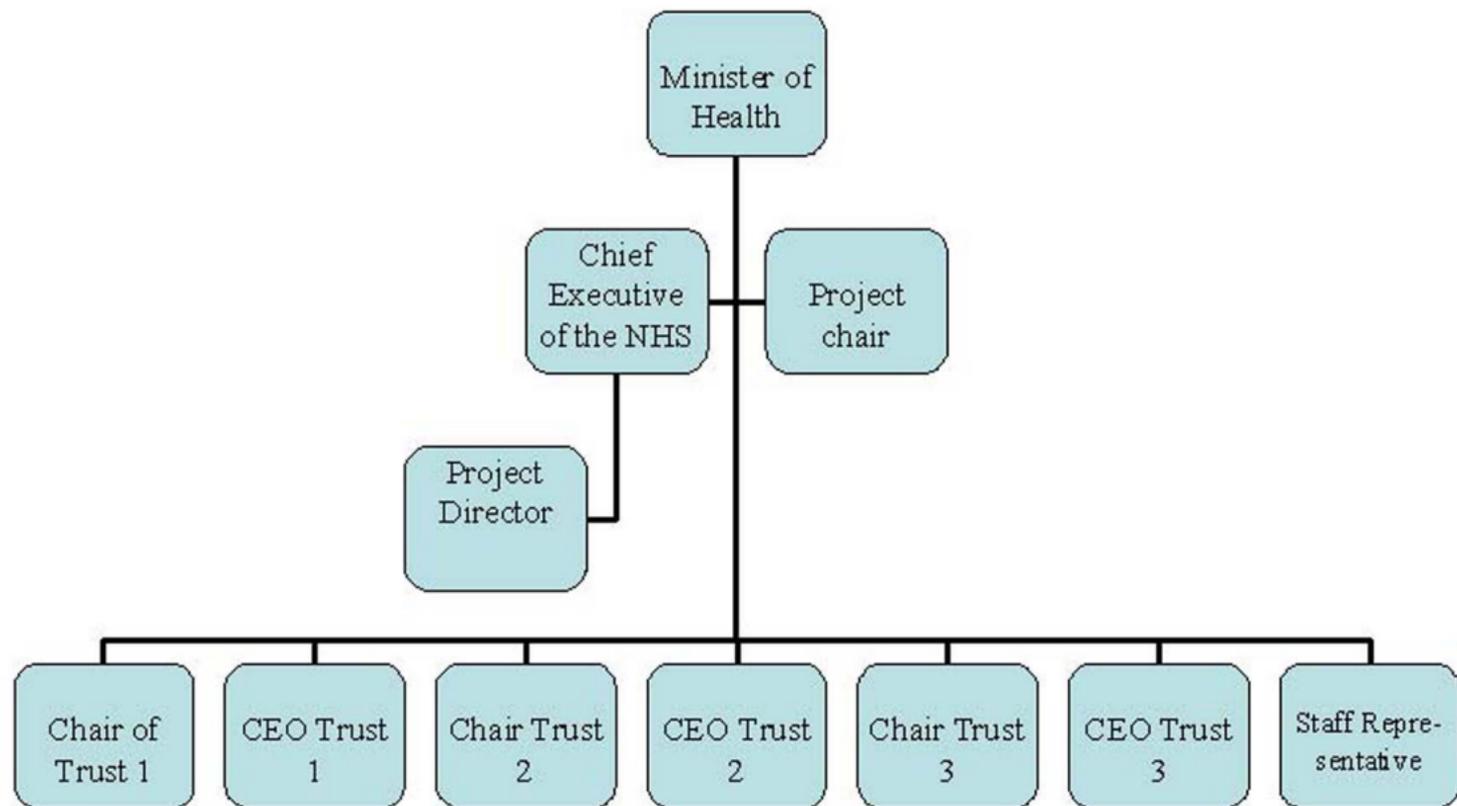


Table 1 The Solution is the problem

Organization studies	Leadership and ethics	Psychodynamics
<ul style="list-style-type: none">• Proliferation of research	<ul style="list-style-type: none">• Shifting ethical paradigms	<ul style="list-style-type: none">• Denial of death
<ul style="list-style-type: none">• Conceptual complexity	<ul style="list-style-type: none">• Role ambiguity	<ul style="list-style-type: none">• Narcissistic personalities
<ul style="list-style-type: none">• Research fragmentation	<ul style="list-style-type: none">• Leadership: is/ought	<ul style="list-style-type: none">• Splitting
<ul style="list-style-type: none">• High hazard, high reliable organization	<ul style="list-style-type: none">• The 'shadow of organization'	<ul style="list-style-type: none">• Corruption
<ul style="list-style-type: none">• Cultural entrapment	<ul style="list-style-type: none">• Totalitarian culture	<ul style="list-style-type: none">• Group fantasies
<ul style="list-style-type: none">• Escalating commitment	<ul style="list-style-type: none">• Market mentality	<ul style="list-style-type: none">• 'Ethnic cleansing'
<ul style="list-style-type: none">• Self enhancement		<ul style="list-style-type: none">• Market mentality
<ul style="list-style-type: none">• Systemic collusion		