

# Studying Organizations: the Revival of Institutionalism

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Most health care in modern societies is carried out within or through organizations. Although hospitals may not be quite as central as they were as recently as the 1970s, primary and community health care are taking increasingly organized forms. The single-handed primary care physician of the 1950s has given way to the member of a group practice or the employee of a managed care organization, forming part of a complex set of professionals, paraprofessionals, health care assistants and managers who deal collectively with patients, government or private purchasers and suppliers. There is a considerable industry in quantitative research that measures inputs to, and outputs from, health care organizations and seeks to correlate them in terms of their relative efficiency, effectiveness and equity. However, these relationships are just that, correlations, and, as such, have limited value in guiding the actions of professionals or managers in designing and developing processes to achieve organizational goals. They also tend to be weak in dealing with aspects of organizational behaviour that are not readily susceptible to numerical measurement, particularly the humanity or civility with which care is delivered. When we come to examine the practice of health care, then, we cannot neglect its organizational contexts and we can only learn about important aspects of these through qualitative methods.

The most important contemporary approach to organizational research in health care is known as *new institutionalism*. This chapter will introduce this approach and discuss how it has been used in qualitative health research, through some examples from case studies in England. It begins by outlining the history

of institutional approaches and the reasons why they have revived in recent years and been used so productively in studies of health care organizations.

## BACKGROUND

The term ‘institution’ has particular associations in health care, where it is often linked to the large-scale, poor quality residential facilities that were historically provided for those who were poor and sick, those who had mental health problems and those who had learning disabilities. These negative images are reflected in the idea of ‘institutionalization’, where a patient or resident has become psychologically dependent on their care environment and unable to function effectively outside this. In the social sciences, however, it has a more neutral sense. An ‘institution’ may take the physical form of a building where particular people perform particular activities. However, the focus is on the activities rather than on the building. Institutions are the structural components of a society, through which its main activities are organized in a regular and repeated manner, for example, the church, the law, the government or the family. They are the rules or principles of collaboration that make it possible for people to cooperate in stable, consistent and predictable ways to achieve their various goals. These rules may be formal (as in written regulations, policies or procedures) or informal (as in cultural norms and mutual expectations). The study of these rules, and the activities that relate to them, is known as ‘institutionalism’.

## INSTITUTIONALISM

People have long studied the ways in which institutions structure societies. You could argue that *The Republic*, written around 380 BCE by the Greek philosopher, Plato, is the foundation of all subsequent work. In this text, Plato examines the institutions of contemporary government in Greek city states, and the ways that they interact, to determine how they could be redesigned in ways that would increase justice and welfare. Within the modern social sciences, however, institutionalism originated in three fields in the late 1800s and early 1900s with studies in the context of what we would now call economics, political science and sociology. It may be described as an approach that examines institutions in order to construct sequences of economic, political and social behaviour and transformation across time. This approach has generated a vast research literature, examining the way that institutions function, prescribing managerial structures and reviewing the behaviour of groups and individuals in organizational settings.

Within sociology, institutionalism is based on the concept of an institution as a social framework that influences human behaviour. Institutions are embedded in social, political and cultural contexts that influence both their general character and their interactions with one another. In contrast to rational choice

approaches, institutionalism does not assume that decision makers are either wholly rational or entirely self-interested: decision makers operate within a context of partial information where choices are constrained by culture and history as much as by economic efficiency. Rational choice approaches were first developed by economists, and later exported to political science and sociology, to explain the emergence and functioning of political institutions. They include such theories as public choice, principal-agent or market theories, all of which emphasize the pursuit of rational self-interest in individual decision making. However, these approaches did not locate these decisions in their context so they tend to be seen as a contrast to, rather than a variant of, institutional theory (Garson, 2008). Rational choice institutionalists focus more on the 'rules of the political game ... the important question is not so much what institutions are but what they represent, an equilibrium' (Lecours, 2005:6). Rational choice models view institutions as governance or rule systems that represent the results of individuals seeking to promote or guard their interests.

## OLD INSTITUTIONALISM

Fifty years ago, organizations were depicted as tightly bounded entities that were wholly separate from any surrounding environment, as 'rational systems' or social machines for the efficient transformation of material inputs into material outputs (Scott, 1987). 'Old institutionalism' studies concentrated on efforts to discover the most efficient 'structures' of command and control for the achievement of the organization's goals. It was recognized that workers could subvert this rational project for the efficient structuring of their behaviour but this could be addressed by removing ambiguity from work design and introducing incentives and controls to shape the workforce into mature and sober workers. This generation identified institutions with formal 'structures' that generated self-contained systems of norms and values consistent with their economic goals (Lecours, 2005).

The analysis of institutions was strongly influenced by Max Weber (1864–1920), a German political economist and sociologist, considered one of the founders of the modern study of sociology and public administration. One of Weber's central interests was the exploration of the role of organizations in the economic life of modern societies, particularly through the emergence of the form known as 'bureaucracy' (Weber, 1946). His contribution is still central to the contemporary study of organizations. He examined the ways in which institutions such as bureaucracy had come to dominate political, social and economic life as a result of cultural shifts in the basis of power and control. He described three main principles – charismatic, traditional and rational–legal – as the possible bases for turning power and control into the legitimate exercise of authority (Scott, 2001). The charismatic principle supplied legitimacy from the presence of an inspirational, often spiritual, leader, the traditional from the legacy of custom and

practice that influenced all members of a social group, and the rational–legal from the group’s compliance with an impersonal body of rules, ideally derived from the rational actions of a democratic government or legislature. This concern for legitimacy has been Weber’s abiding legacy to institutionalism. How do these bases of authority generate particular kinds of institutional forms? For example, how did the charismatic basis of the authority of Christ or the Prophet Mohammed come to be transformed into the powerful bureaucracy of the Catholic Church on the one hand and into the loose and often conflicting networks that characterize Islam, on the other? Weberian ideas about bureaucracy, which were strongly influenced by his observations of the Prussian state that dominated Germany during his lifetime, used to have a strong influence on thinking about public sector organizations. Government intentions, expressed in laws and regulations, would be implemented by managers in an impartial and disinterested fashion to supply a planned service to citizens through frontline or ‘street-level’ staff: if public sector ‘management structures and processes, channels of communication and clarity of communication are ‘right’ effective action will be assured’ (Barrett and Fudge, 1981:9).

Another important influence on old institutionalism studies was John Commons (1862–1945), an institutional economist. Institutional economics dominated in the United States until the 1920s when it was displaced by the neoclassical approaches that are almost universally adopted today. Unlike contemporary economics, Commons and his followers saw economics as a discipline that began from direct observations of economic life and then tried to build theories to explain them. Neoclassical economics tends to start from a set of assumptions about individually rational behaviour under ideal conditions, to develop models of the consequences, adjusting these to produce what is judged to be an optimum outcome and then seeking to propose ways of remaking the real world so that it approximates more closely to this ideal. If you start from the real world, however, as Commons (1910; 1934) did, you necessarily become more interested in collective actions and the ways in which these give effect to, or constrain, individual choices. You may also have a more diverse view of desirable outcomes: while Commons was certainly interested in the efficient use of scarce resources, which is the core problem for all economists, he took a much broader view of efficiency than would many contemporary economists. For him, wealth distribution stood alongside wealth maximization as legitimate concerns for the economist, and he made significant contributions to the expansion of workers’ protections under law in order to promote this.

A third important figure was Everett Hughes (1897–1983), an American sociologist who drew on both Weber and Commons in developing an ecological approach to the study of institutions that formed the theoretical frame of reference for numerous studies of class, status, political power, industrialization, work and occupations. Hughes (1956; 1962; 1971) took up Commons’ idea of organizations as ‘going concerns’, sites of collective action, and linked this to ecological thinking about the ways in which socioeconomic systems offered niches for potential colonization that, in turn, shaped the going concerns that

could compete to occupy them. Institutions were not self-sufficient and autonomous, but existed in relation to one another and to a wider cultural field in the way that Weber (1946; 1968) had described.

By the 1960s, however, institutionalist approaches were in decline in the face of rationalist theories of economic and social organization. Commons' work had been marginalized within economics since the late 1920s, although Weber's thinking continued to be influential in some areas of sociology. The work of Hughes and his students was respected within sociology, but not considered as a pathway to follow so much as an anachronism left over from an earlier age. The project of remaking all social sciences after the model of economics seemed irresistible. Apart from research in sociology, interest in 'old institutionalism' largely died out during the early 1950s. However, in 1976, James March, Professor of Political Science and Sociology Emeritus at Stanford University, and Johan Olsen, a Professor of Political Science at the University of Oslo (March and Olsen, 1976), published a major restatement of institutionalist arguments that reasserted the value of conceptualizing organizations in terms of norms, values and interrelated rules and routines.

March and Olsen regarded institutions as 'expressing norms of interrelated roles and routines that define appropriate actions in terms of relations between roles and situations' (1989:21). Rules are sets of expected behaviours, sustained by trust that institutions impose on their members. Rules may be either formal or informal: while formal rules might be changed, informal rules are difficult to change. In sum, March and Olsen presented a more holistic view of action within organizations, seeing this not just as an aggregate of atomized individual choices but as profoundly influenced by the informal and symbolic dimensions of culture. Institutional cultures are as powerful a source of sanctions as rational management in making some courses of action available to members of an organization and blocking others. The possibilities for action are simultaneously a source of opportunity and control: members can do *these* things, but not *those* things. At the same time, they always have an element of indeterminacy – they must be recognized by members, interpreted by them and applied by them in a highly contingent organizational environment.

Where the 'old institutionalism' was thought to be descriptive, a-theoretical and narrow-minded, this 'new institutionalism' embedded organizations with their societal context as a source of variability and began to develop a base of theoretically founded generalizations from comparative investigations of different organizations operating within the same social field, or of similar organizations operating within different social fields (Lecours, 2005).

## NEW INSTITUTIONALISM

A series of articles by March and Olsen (1976; 1984; 1989) defined the revolution against the methodological individualism, behaviourism and formal

rationality that had marked their immediate predecessors. The movement that came to be known as 'new institutionalism' developed through a series of contributions, including Meyer and Rowan (1977), Zucker (1977), DiMaggio and Powell (1983), Tolbert and Zucker (1983), Meyer and Scott (1983), and Powell and DiMaggio (1991). It was a collective reaction against rational choice accounts of political and organizational behaviour that saw this as an aggregate of individual responses to economic and technological stimuli that had, themselves, no social origin or context (Powell and DiMaggio, 1991). These authors sought different answers to questions about how social choices are shaped, mediated and channelled. Although previous organizational researchers had recognized that organizations possessed both formal (governed by rationality) and informal (governed by culture) dimensions, they had tended to treat the latter as pathological, an obstruction to efficiency and effectiveness. New institutionalism transcended these distinctions, insisting that rationality was itself a cultural form, the product of a particular and contingent historical moment, and was not to be given precedence over the other sociocultural elements in the relations between members of an organization, and between those members and the environment in which the organization operate.

For the old political institutionalists, institutions were material structures, comprising constitutions, cabinets etc. 'Institutions referred to the state or more exactly to 'Government' (Lecours, 2005:6). New institutionalists, however, do not define institutions in material terms, as action that is coordinated by its location or technology. They focus instead on the way actions are coordinated by shared references to beliefs, values or cognitive scripts (Scott, 2001). These ideas contribute to a 'mythic' self-description, which members create as they form organizations, or learn, as they join, which defines the organization's goals, structures and boundaries in cultural and normative terms (Dingwall and Strong, 1997). Sociological institutionalists see organizations as cognitive frameworks rather than as the formal structures on organization charts, which are merely one representation of the organization among many that are possible. Institutions are constructed by the actions of their members with reference to these shared frameworks of ideas, which can be used both to design and develop actions – and to make sense of the actions of other members or of outsiders. Although change may be provoked by economic or technological developments, these are always filtered through the organization's culture and the ways in which it is used by members (Lecours, 2005).

In particular, the new institutionalists suggested that Weber had overemphasized the competitive market place as the major environmental driver for organizational change (DiMaggio and Powell, 1983). Powell and DiMaggio (1991) preferred to read Weber in a way that stressed his analysis of legitimacy that the main goal of organizations was to act in ways that would be regarded as legitimate by key actors in their environments and would, as a result, win them resources from those actors. Those resources might be economic, or they might be essentially symbolic, but capable of being translated into economic or political



support if the organization came under challenge. When forced to choose, organizations select options that preserve and enhance their legitimacy.

The most important way to achieve legitimacy was to adopt cultural forms that either copied those of the most successful organizations operating in the same field or that reflected the models preferred by the most powerful actors in the environment. The result was an 'iron cage' of 'institutional isomorphism'. This involves three mechanisms: *coercive*, where external audiences compel conformity, often through law or regulation; *mimetic*, where uncertainty leads the organization to adopt the practices of their most successful competitor, however 'success' is defined; and *normative*, often where a strong professional interest that cuts across specific organizations drives the adoption of particular values and beliefs by all of them (Powell and DiMaggio, 1991:67). Legitimacy always has a 'ceremonial' dimension – it is not enough just to respond to isomorphic pressures, an organization must be *seen* to have responded (Meyer and Rowan, 1977). However, ceremonial action can remain divorced from an organization's day-to-day activities and working practices. Compliance would often obstruct these, although the *appearance* of compliance may be crucial to external legitimacy and the flow of resources from the environment to the organization.

Powell and DiMaggio (1991) originally argued that the new institutionalism was more concerned with 'persistence' rather than change and that 'the legitimacy imperative' acts as a source of 'inertia'. As a result, new institutionalism emphasizes the homogeneity of organizations and the stability of institutional components (Powell and DiMaggio, 1991:13/14). However, Oliver (1991:165) proposes that new institutional theory can explain 'not only homogeneity and isomorphism in organizations but also heterogeneity and variability'. He links this with resource-based theory to suggest that where institutional pressures exert strong influences, competitive advantage might be gained through heterogeneity in resources and capability. If all organizations wholly succumbed to isomorphism, no one would have any competitive edge. Managers must have some degree of freedom that allows them to manage their adaptation to environmental pressures in order to gain such an advantage.

Citing work by Edelman (1992); Dobbin and Sutton (1998) and Edelman et al. (1999), Powell (2007:4) acknowledges their findings that organizational fields are 'fragmented, contained multiple institutional influences and were thus subject to ambiguous requirements'. He also recognized that organizations 'helped construct the law and created the regulations that shaped 'best' practice' (Powell 2007:5). The heterogeneity of response to isomorphic pressures should renew concern with the role of agency in institutionalization. This should be seen as a political process, reflecting the relative power of different agents. This is apparent in the changes and increases in rules, normative systems and cognitive beliefs which 'eroded the sovereignty' of physicians and changed organizational fields as described by Scott et al. (2000). Powell accepts that it was a limitation of the original work to assume that ideas and practices 'diffuse seamlessly' and acknowledges the importance of political opportunity and cultural frames in shaping

diffusion so that 'social movements are critical to the acceptance of ideas'. Further analysis of the 'forces that account for institutional heterogeneity and homogeneity' would 'bode well for the robustness of institutional analysis' (Powell, 2007:8).

New institutionalism, then, provides an alternative to economic analyses, offering explanations as to how institutions, although created in different ways, end up having similar structures and how these institutions might shape, and be shaped by, the behaviour of their members. It focuses on the 'cultural basis of all organizational structures and action' and views 'organizational boundaries as open and fluid so that the cultural foundation of action was not contained within the organization but reflected the organization's interactions with its environment' (Dingwall and Strangleman 2005:248).

## NEW INSTITUTIONALISM AND HEALTH CARE STUDIES

New institutionalist approaches have influenced a number of studies of health care organizations. Scott et al. (2000) examined the transformations that had occurred in the medical care systems in the San Francisco Bay area since 1945. Conducted during the 1990s, a period described as one of great turbulence in US health care, Scott et al. describe the changes in the Bay Area health care organizations and their responses to external forces, particularly in the adoption of new organizational forms. Scott et al. showed how these changes related to three institutional eras: professional dominance (before 1965), federal involvement (1966 to 1982), and market forces (1983 to 1999). The authors describe each era in detail, relating changes both to sociodemographic trends in the Bay Area and to shifts in regulatory systems and policy environments at local, state and national levels.

There has also been increasing interest in applying this approach to studies of the English National Health Service (NHS) which has undergone extensive and rapid change in its environment and organization over the last thirty-five years. One example is the way that 'in the space of four years the NHS went from a situation where there were no hospital Trusts to one in which almost every provider had converted to the Trust format' (Pollitt et al., 1998:98–99). In the NHS, coercive isomorphic pressures derive from the state's requirement that NHS Trusts conform to certain processes, policies and protocols, in order to be viewed as legitimate. Arguably, however, these changes are largely ceremonial. While they shape organizations in similar ways, they lead to a focus on outputs that are unrelated to the real work of the organization. This is more influenced by normative isomorphic pressures from the process of professionalization (Powell and DiMaggio, 1991). Organizations are also influenced by the differences that result from the varied training and philosophical approaches that underpin the health professions. These generate a set of cognitive bases that, on the one hand, unify professions and, on the other, contribute to conflict between them. Professionalism creates a countervailing system of legitimacy that links workers



across the different organizations that hire them. Currie and Suhomlinova (2006:1), for example, 'highlighted the influence of regulatory normative and cultural-cognitive aspects of institutions operating in the health field on the boundaries that impede knowledge sharing'. Managers, orienting to coercive pressures from the state, did not always recognize the cultural and political dimensions of knowledge sharing, oriented to within the normative frameworks of professionals, so that 'knowledge sharing across [professional] boundaries will be difficult to realize'. As Dingwall (2009) notes, the result has been a state initiative to undermine professional authority, in the name of quality and safety, in order to weaken the normative influences that check the state's coercive interventions. My own work (Staniland, 2008) investigated the implementation of clinical governance, (a quality initiative) into one English NHS hospital Trust and showed, however, that external legitimacy, in response to state coercion, could be achieved, to the benefit of the organization, without any evident improvement in the quality of care received by patients.

### AN INSTITUTIONALIST ANALYSIS OF CLINICAL GOVERNANCE

Clinical governance was introduced into the NHS as the organizational response to a perceived decline in clinical standards, service provision and delivery, reinforced by media coverage of major clinical failures (Harvey, 1998; Scally and Donaldson, 1998; Swage, 2000). However, there is considerable dissent about its meaning, substance and essential nature, which were not clearly articulated by the 'official' definition as 'a framework through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (DH, 1998:33; See Staniland, 2008). However, it is generally accepted that it requires organizations to carry out a number of component activities such as standard setting, in the form of protocols and policies; risk management; audits; adverse incident recording; and training, reflection and professional development, in the form of a 'Learning Organization'. In this sense, clinical governance can be seen as a coercive pressure that NHS Trusts must respond to in order to sustain their legitimacy with the state. If they are successful, certain rewards follow; if they are not, there may be sanctions, particularly on the Chief Executive Officer.

The NHS Trust studied was broadly typical of any large university teaching hospital in England. Wards were grouped into directorates and departments actively engaged in teaching and research. The Trust employs over 4,200 staff and trains approximately 300 medical students. Three hundred student nurses and therapists are accommodated on practice placements in any one year. On a day-to-day basis, the Trust is able to handle 1,000 outpatients and may treat up to 250 patients in the Accident & Emergency Department. There are in-patient facilities for over 900 patients and the day surgery unit can treat over 70 patients on a day case basis.

The study adopted an ethnographic methodology. Data were obtained over a two-and-a-half-year period by the documentary analysis of paperwork related to the implementation of clinical governance, such as public and official minutes of meetings, policies and procedures; observation of clinical governance meetings and semistructured interviews with nurses and stakeholders involved in clinical governance implementation within the Trust; and day-to-day observation of ward activity. During my fieldwork, I attended corporate Trust level clinical governance meetings and analysed their decisions. I tracked and asked about intranet information resources available for hospital staff, conducted staff interviews and observed everyday practice on Elderly Care and Neurosciences wards. Hammersley and Atkinson's (1995) classification of official, formal and informal documents was utilized. Official documents included public records, official data and statistics. Formal documents were those circulated to committee members within the Trust (such as annual reviews, reports, protocols, strategies and action plans). Informal documentation was my own field notes and recordings taken during meetings and periods of observation. These were analysed using established conventions for qualitative data (Bryman and Burgess, 1994).

If documents were considered at a superficial level, they appeared to be an appropriate account of what had taken place at the meetings. However, when the progress of agenda items from the official minutes was tracked and compared with my own observations of the same meetings, I found that important issues identified for action simply did not appear in the documentation again. There were many discrepancies between the official documentary records and what was actually done and observed and, from the summary of events, it was apparent that information given to committee members varied. The attendance of key personnel at meetings was erratic, with some members never appearing. Approval of protocols and policies, (a main function of the committee), appeared at times to be just a paper exercise (ten protocols being endorsed in nine minutes on one occasion), and many inconsistencies were found in these documents. More importantly, the dissemination, implementation and embedding of protocols in working practice was obscure. On this basis, the main corporate clinical governance committee was considered to be an essentially 'ceremonial' body.

From a new institutionalist perspective, however, the fact that it was ceremonial did not mean that it was ineffective or irrelevant, merely that its role needed to be correctly understood. This committee successfully met the 'coercive' requirement of central government that such a committee must be set up if the institution were to be recognized as legitimate by its main funders and most powerful stakeholders. The committee was not actually required to show that it had improved the quality of care but to show that it had conducted appropriate business in an appropriate way, as evidence by the documents that it created. As Murphy and Dingwall (2003:66) suggest, documents 'provide valuable evidence about what people and organizations would like to be thought to be doing' rather necessarily about what they have actually done. In Garfinkel's (1967) terminology, the committee's records are 'contractual' rather than 'actuarial': they are not

literal accounts of what happened but evidence that the appropriate personnel went about their business in a competent way.

Other meetings, involving lower levels of Trust management in relation to clinical governance, were also observed. These meetings were supposed to disseminate the clinical governance process within the Trust. My observations identified the difficulties experienced by staff in trying to make sense of the Trust's corporate intentions. The internal governance systems created by the Trust were fraught with problems that were not being addressed at higher levels. The information on protocols and policies placed on the hospital intranet, for example, was unusable as a tool to inform practice, because few staff had access to IT and the organization's search tools were poor. Nevertheless, complaints made to higher-level management about system weaknesses failed to initiate any change. Again, this underlined the information's success in its ceremonial function, it was posted on the intranet and its availability could be audited, although there was no expectation that anyone would actually make use of it. No one need refer to this information in order to carry out their job, but the organization could demonstrate that the work must have an evidence base, because, if it was carried out within the organization, it must necessarily comply with the protocols. Should the Trust's legitimacy be questioned by its stakeholders, they could be shown the body of information posted on the intranet. Should everyday practice be shown to be noncompliant, management would be buffered from the consequences, because the policies had been stated, even if they had not been accessed.

I conducted semistructured interviews with thirteen nurses of various grades from Assistant Director of Nursing Services to recently qualified Staff Nurses, and fifteen semistructured interviews with senior members of other professional groups who had some responsibility for clinical governance within the Trust. From these, I generated a number of theoretical categories including 'Somebody Else's Job' and 'Real Work'.

It quickly became clear that there was no consensus on what 'clinical governance' meant within this group. The interpretation varied with the grade of the informant. Nurses involved in higher-level management gave 'ceremonial' examples of how the clinical governance implementation systems worked:

Clinical governance is a framework within, which the Government have brought in to embed quality into everyday practice. It has seven pillars and those seven pillars provide a framework, to enhance care and quality (Matron).

Staff at the bedside, however, found it difficult to describe or identify any change that they could clearly relate to clinical governance, apart from the requirement to complete the increased amount of documentation that the systems generated:

I don't know, it sounds as if I am whingeing, but it is time constraints, staffing levels, although the Trust will say, have remained consistent, they haven't, trained staff have been reduced and reduced and reduced, replaced by people like assistant practitioners, who are not trained nurses at the end of the day. So that puts more and more pressure on qualified

nurses, paperwork has quadrupled, the number of meetings that are mandatory has gone through the roof and it all adds to time constraints that previously were not there (Ward Manager).

We're busy on the ward, the shifts busy, it comes to the end of the day you think do I want to go to a meeting or do I want to go home and it's bad you choose you want to go home I mean ... We were told the X-ray dept, once, I remember them saying we've got protected time this morning so we're not doing any, (work) and I remember thinking well, if they can get it, but we're never going to get protected time because who's going to be left on the ward if that happened? (Senior Bedside Nurse).

While senior professionals in medicine and nursing could give well-articulated accounts of clinical governance, it was much less clear whose responsibility it was to implement. Professionals saw it as a management tool to improve quality, and managers saw it as a framework for professionals to improve their own practice. A senior management member of the Trust responded to my question about designation of roles and responsibilities stating:

It is not my responsibility. It's nobody's responsibility that is the problem. ... Everyone thought it was 'Somebody Else's Job'.

This played out particularly strongly at lower levels. In my interviews with nurses, they recurrently complained about the lack of communication with managers, with the result that managers did not appreciate what happened at ward level and the problems that existed. I wanted to establish how managers identified their role in relation to the ward areas they managed and asked if they spent any time visiting the wards:

No I haven't, because nursing isn't my field, so mine is the overall picture of the organization, really about the systems, and getting the systems right for the Board. ... I haven't no (GM 4).

The majority of managers interviewed clearly felt that they could manage their directorates without actually visiting the areas that they were responsible for managing and relied on communicating at meetings that nurses did not attend. This lack of contact reinforced the communication problems that the ward sisters had highlighted. It was extremely hard to identify any individual who took corporate responsibility when things went wrong. Again, it is important to stress that, from an institutionalist perspective, this is not necessarily pathological. The existence of the clinical governance system satisfied key external stakeholders but the lack of implementation avoided internal conflict between managers and professionals, while buffering each group from the potential implications of errors or failures. By defining implementation as 'somebody else's job', it became 'nobody's job', so that nobody could be held accountable for any adverse consequences.

Finally, I investigated whether nurses and other stakeholders at the point of care thought that clinical governance had achieved its ostensible objective of improving the quality of patient care, my original interest in conducting this study. As clinical governance had clearly increased the amount of paperwork at ward level, I was particularly interested in the auditing systems of clinical

governance, and if staff could see any result linked to the improvement of care as a result of these. What this yielded, however, was a contrast between ceremonial work and 'Real Work'. Real work was the practical, everyday care of patients. Ceremonial work disappeared into some vague ether, where other departments might, or might not, make some use of it to sanction frontline staff:

We are aware that when we deliver the care it's audited, our documentation's audited, our care plans audited. We have audits like infection control so everything's looked at and we know that where we, what we're good at and to continue doing and where we're perhaps falling behind on something that we're not doing that we can learn from (Junior Ward Sister).

Compliance with the ceremonial order was, however, very burdensome, involving much collation of documentation driven by unfriendly IT systems that failed to integrate and return this in any form usable at lower levels.

In respect of the paperwork around clinical governance I would say that possibly half of my time is spent providing either evidence, auditing, or responding to clinical governance issues. ... With the adverse incident reporting again, it's not the actual paperwork it's the system on the computer that doesn't make it particularly easy. But my web master file is absolutely full of it and there is no way of identifying, either on the system, of which, say like. If one of the gatekeepers (Clinical Governance Facilitator) phoned me up and said, I needed some information off one of the adverse incidents she got, it's number 504, there is no way on the system you could find that without going through every single one and there must be thousands, because you've got the original report, my response, the manager's form back then you've got an incident accept, so the file is enormous and there is no way you can link any of them together (Ward Manager).

Time spent on this was not available for either direct care delivery or for addressing management issues. We should not necessarily take at face value the professional consensus in my interviews that the integrated approach of clinical governance had brought about little or no identifiable improvement in the quality of bedside care. Interviews with professionals often generate accounts that are designed to project their claims to autonomy and their resistance to managerialist interventions like clinical governance.

On the other hand, these comments were entirely consistent with my own participant observation data from the wards where I found that actual practise showed little evidence of change attributable to clinical governance and that frontline staff had little awareness of the Trust's formal goals. Where they did, they found them to be ambiguous and unrealistic on a day-to-day basis, which resulted in a lack of commitment. In the specific area of clinical governance, there was little evidence of active knowledge management or organizational learning. Fundamentally, there was no interest in 'trying to understand and conceptualize the nature of knowledge that is contained within the organization' (Easterby-Smith and Lyles, 2003:3). However, as I have stressed, this does not necessarily mean that the systems had failed. They had to be understood in different terms, where they were highly successful in delivering external legitimacy.

Ultimately, legitimacy was more important than improving quality or effectiveness. During my fieldwork, the Trust obtained a recognition status from its

insurer for its structures and systems and recognition that led to a significant reduction in insurance premiums. The Trust's documentation was considered to be among the best of any hospital in the region, which brought financial benefits that could be invested in service improvement. The value of the new institutionalist perspective lay in the way it helped me to understand that the clinical governance system could still be important, successful and valuable to the Trust despite the complete absence of any evidence that it was contributing to its ostensible goal of improving everyday clinical practice. Although much of this badly needed improving, from a professional perspective, the legitimacy gained for the organization by its ability to create the appearance of compliance with the coercive expectations of its main stakeholder created a space in which such change could, in theory, occur. The problem was that the preoccupation of line management with this ceremonial system inhibited any engagement with the practice of frontline care delivery that could actually bring about improvement.

If a hospital demonstrates conspicuous, but ceremonial, compliance with the expectations of its stakeholders everyone is happy, and it becomes legitimate. However, we need to understand this only affects its ceremonial order, rather than its workplace culture, delivery of bedside care, patient experience and recognition of patients. Legitimacy is the precondition of organizational success rather than its consequence. Clinical governance in the hospital I studied is not a failure. Its lack of impact is an unintended consequence of an attempt to introduce reforms based on an inadequate understanding of how organizations work. Successful reform would demand both a better-informed approach to organizational change *and* the management of stakeholder expectations to have this approach accepted as legitimate.

## CONCLUSION

The last forty years have seen a general revival of institutional theories in both political and social science. This chapter has explored these perspectives by outlining old and new institutionalism approaches and discussing their implications for social science and health care. While it is evident organizational studies of the NHS have not been prominent in recent years, and that the study of the hospital as a social organization has declined globally, this chapter has given examples of studies that have utilized institutional theories as useful frameworks. As Davies (2003) has argued, health care organizations are very different from the hospitals studied by medical sociologists forty years ago and more research is needed on their contemporary forms and practices.

New institutionalism theory offers a coherent framework to understand why organizations adopt procedures and practices which appear to promote uniformity and standardization. However, they can also reveal some of the complexities – and local difficulties – of such processes in a health care setting.



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