Human Relations
[0018-7267(200205)55:5]
Volume 55(5): 537–564: 023427

SAGE Publications
London, Thousand Oaks CA,
New Delhi

The corruption of managerial techniques by organizations

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ABSTRACT

Public sector organizations are under pressure to adopt private sector tools to sustain legitimacy despite uncertainty about the compatibility of the techniques with this context. We explore the consequences of the misfit between the theories underlying two widely adopted managerial techniques (strategic planning and quality management) and the pluralistic power structure and values of public hospitals. We identify four scenarios of adaptation and use qualitative data to examine their empirical prevalence. We suggest that when the compatibility gap is large, there is greater likelihood that formalized techniques will be captured by and integrated into existing organizational dynamics (corruption of the technique) than that the technique will change these dynamics in a way consistent with its objectives (transformation of the organization). We examine the implications of our observations for understanding the role of managerial techniques in organizational change.

KEYWORDS

hospitals ▪ managerial techniques ▪ organizational change ▪ quality management ▪ strategic planning

It is notorious that managerial practice is influenced by waves of fads and fashions (Abrahamson, 1991, 1996; Gill & Whittle, 1992). New managerial techniques are tried by pioneering organizations, achieve some widely publicized successes and become more attractive to others seeking to improve their operations and/or their image. As more organizations adopt the

innovation, sometimes in less propitious contexts, the performance outcomes of the technique become more questionable, eventually leading to scepticism and disaffection (Abrahamson, 1991). But by then, a new technique has appeared to capture the enthusiasm of a new wave of management reformers.

The pattern described above reflects an institutional perspective in which social processes are more powerful than efficiency imperatives in determining whether organizations will adopt new techniques (Meyer & Rowan, 1977; Westphal et al., 1997). These social processes include pressures for conformity to regulatory norms, links to organizations that diffuse managerial techniques (e.g. academia, consultants, etc.) and the informal sharing of ideas within organizational networks (DiMaggio & Powell, 1983).

Although all organizations are susceptible to institutional influences, these pressures seem to take on greater importance in certain organizational fields, such as in domains where professional associations play a major role (e.g. accounting, medicine and law) and in governmental sectors where market pressures are dampened (Greenwood & Hinings, 1996). In the public sector where there may be limited capability to assess simple bottom-line outcomes such as profitability, it becomes tempting for those who evaluate these organizations (governments, regulatory bodies, the public) to judge them on the basis of their processes. In such circumstances, the adoption of techniques that are viewed as rational, modern and progressive can enhance an organization's legitimacy. Time after time, the source of these techniques has been private sector firms. There is, in fact, a whole school of public administration that promotes the idea that public sector organizations should be managed more like business firms (e.g. Pollitt, 1990; Osborne & Gaebler, 1992). Indeed, the techniques are often promoted on the basis that they will make the organization behave more like a business in valued ways (e.g. by becoming more responsive to customers). Yet, they are inserted into a context that is *not* that of a business firm, and as many writers have suggested, public sector organizations have several distinctive features. For example, their environments are dominated by regulatory bodies rather than by customers, and they are often characterized by limited competition, low autonomy, diffuse power and multiple objectives (Rainey, 1991; Nutt & Backoff, 1992).

So what happens then? This is where this article attempts to make a contribution. In particular, we investigate one highly institutionalized organizational field, that of public sector hospitals, and we examine what happened when two different managerial techniques with roots in the private sector (strategic planning and quality management) penetrated it. Our focus is on the dynamics associated with the implementation of these techniques. We first explain our conceptual framework. We then describe the methods

used in our empirical work. We proceed to an analysis of the assumptions behind the techniques and a corresponding analysis of the specific organizational context. The patterns of implementation of each technique are then described using the initial framework as a tool. This leads us to conclude that when there is a gap between the assumptions underlying a technique and the context in which it is applied, the organization will tend to 'corrupt' the technique rather than allowing it to transform the organization. We then discuss these findings, engaging with debates in the literature on management fads and fashions, organizational change and the potential for public–private sector transfer.

Conceptual background

This article begins from the premise that any managerial technique is founded on a number of assumptions concerning the pattern of roles and the power distribution of key actors in the organizational system and that it is possible to identify these assumptions through an analysis of the discourse surrounding the techniques. For example, Mintzberg (1994) carried out a detailed analysis of the assumptions underlying strategic planning. Hackman and Wageman (1995) and a special issue of *Academy of Management Review* (Dean & Bowen, 1994) investigated the theoretical foundations of total quality management. Based on this type of analysis, it can be seen, for example, that strategic planning tends to assume that top management has the power to establish strategic direction (Mintzberg, 1994). Similarly, quality management techniques tend to suppose that customers have the power to penalize organizations that do not satisfy their needs (Hackman & Wageman, 1995). These theoretical patterns (derived from the literature on the technique) can be compared with the existing pattern of roles and power distributions in a given domain (derived from the literature and empirical studies). The difference between the two we label a 'compatibility gap'. The question then is: What happens when incompatible forces meet?

We suggest that there are four modes of handling this gap. First, the technique may transform the organization so that its functioning fits the theory behind the technique ('*transformation*'). Here, the gap is closed by the organization moving towards the technique. If the gap is large, this represents a radical change. Second, the technique may be adapted to make it more compatible with the organization without destroying its aims (this is called '*customization*' by Westphal et al., 1997). Customization implies closing the gap by adapting the technique *and* adjusting the organization. Third, the technique may be adopted superficially, retaining only a ritual function as

described by Meyer and Rowan (1977). We call this '*loose-coupling*' because it represents maintenance and tolerance of a gap. Finally, the technique may be captured and used to reproduce existing roles and power structures. We call this case '*co-optation*' or more provocatively 'corruption' as in the title of this article. Here the gap is closed by bringing the technique closer to the organizational pattern. The four modes are illustrated in Figure 1.

This typology of modes of interaction between technique and organization was inspired by the literature on cultural integration. For example, Gordon (1964) and Cox (1991) used a similar typology to analyse the integration of immigrants. Nahavandi and Malekzadeh (1988) develop a similar model to understand cultural integration in mergers and acquisitions. Finally, two authors of the present article used a similar frame to study leadership succession (Denis et al., 2000).

This framework suggests several empirical questions. First, for any specific case, what is the nature of the 'compatibility gap'? Second, in practice, how is the gap handled? Which of the four patterns occurs, if any? Why? We now describe the empirical data and methods used to investigate these issues.

Empirical data and methods

Our analysis draws on data collected over a period of 15 years in the context of four different studies involving hospitals. Three of the studies focused specifically on the role of management tools: formal analysis in one study (Langley, 1988, 1989), strategic planning in a second (Denis et al., 1995) and quality management in a third (Lozeau, 1997). The fourth study focused on strategic change, but data were also collected on strategic planning as a contributor to this process (Denis et al., 1996). Most of the data are qualitative

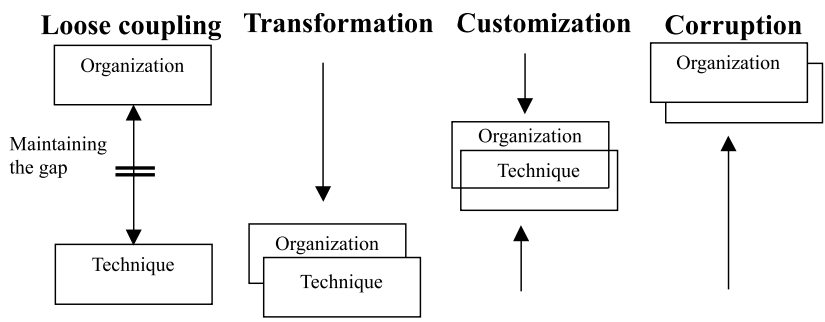

Figure 1 Approaches to dealing with the compatibility gap

and include interviews, documents and in some cases, direct observations (site A). Interviews included open-ended questions about (a) the context and motives surrounding the adoption of the technique, (b) the processes used to operationalize it and (c) its impact.

Table 1 summarizes the data sources. We have both in-depth case materials (two hospitals for each technique) and cross-sectional survey interviews (33 hospitals for planning; 12 for quality management). Research sites were in or near Montreal, creating a homogeneous sample in terms of the institutional and market environment. Taking the technique to be the unit of analysis, our data set thus represents two complete case studies of the penetration of a managerial technique within a similar organizational context. The cross-sectional samples provide coverage of variations in implementation patterns, while the in-depth studies allow detailed analysis of the processes associated with these patterns. Most hospitals in the quality management sample are also in the planning sample, although the data were collected five to six years later. Site A was the first hospital to implement strategic planning in Quebec (in 1979) and was undertaking its second planning exercise

Table 1 Data sources

	Case 1: Strategic planning	*Case 2: Quality management*
Cross-sectional data	1988–90 • 59 Interviews in 33 hospitals (in most cases, one administrator and one physician per hospital) • Strategic plans for 19 hospitals	1996 • Interviews with quality management coordinators in 12 hospitals • Interviews (six) with regional managers, experts and accreditation personnel
In-depth cases	*Site A*: 1983–4 (ongoing with follow-up) • Interviews with 13 managers and professionals • Observation of 13 planning meetings • Documentary evidence • Three follow-up interviews 1988–90	*Site Alpha*: 1996 (retrospective) • Interviews with 17 administrators, professionals, middle managers, employees • Documentary evidence
	Site Z: 1991 (retrospective) • Interviews with 16 managers and professionals • Documentary evidence	*Site Omega*: 1997 (retrospective) • Interviews with 12 administrators, professionals, middle managers, employees • Documentary evidence

at the time of the study. Site Z was chosen because of its involvement in a strategic change effort. Sites Alpha and Omega were selected because they had reputations for successfully implementing quality management. Thus, if there is any bias in these studies, one would expect it to be towards more intensive and transformational patterns of implementation.

The data were analysed using descriptive chronologies, thematic coding and tabular displays (Miles & Huberman, 1994). Coding categories reflected the three themes addressed in interviews: the context and purposes behind the use of the technique, the processes used and their impact (Langley, 1988, 1989; Denis et al., 1995; Lozeau, 1997). The development of cumulative insights across studies was facilitated by the common research questions, and by the participation of one of the authors in all the studies as investigator or as advisor.

Prior to presenting our observations, however, we need to establish the nature of the 'compatibility gap' between the theoretical assumptions underlying the two techniques and the dynamics of the context examined. For this, we rely on previous theoretical work on the techniques and on prior analyses of the organizational form under study.

The compatibility gap

There have been several attempts to synthesize the central core of the discourse on 'strategic planning' and 'quality management' using the classic texts of each domain. Rather than repeat these analyses here, we will use them as the basis for our arguments.

The most detailed analysis of the discourse on strategic planning was carried out by Mintzberg (1994) in his book: *The rise and fall of strategic planning*. Paying particular attention to the classic work of Ansoff (1965) and Steiner (1979), but also drawing on a wider literature, Mintzberg (1994) identifies three premises behind strategic planning: (1) that strategy making should be a controlled, conscious and formalized process decomposed into distinct steps and supported by analytical techniques; (2) that responsibility for the overall process rests with the Chief Executive Officer in principle, although in practice, execution is delegated to staff planners; (3) that strategies come out of this process fully developed, often as a position, so that they can then be implemented through detailed attention to objectives, budgets, programmes and operating plans of various kinds (Mintzberg, 1994: 42).[1] Mintzberg's (1994) image is of a top-down analytical process that produces a fully integrated strategy (or set of interlinked decisions about what activities to pursue and how to pursue them), positioning the

organization with respect to its environment. This is then implemented through a hierarchical process of delegation and control.

While strategic planning deals with macro-level decisions, quality management is concerned with micro-level operational decisions. Moreover, while strategic planning can accommodate a variety of goals including but not limited to quality, in contrast, quality management techniques insist on satisfaction of the customer as the prime objective. Analyses of the discourse on total quality management (TQM) by Dean and Bowen (1994), Spencer (1994) and Hackman and Wageman (1995) draw attention to other key components of the approach put forward by the original writers on quality (Crosby, Deming, Ishikawa and Juran). These include a need for visionary leadership to communicate and reinforce the adoption of the quality imperative, the use of 'rational' measurement and process analysis techniques to identify quality failures and continuously improve processes and the creation and empowerment of multifunctional teams to study and implement process improvements. As Hackman and Wageman (1995) note however, different proponents of the techniques adopt different perspectives on appropriate incentive mechanisms. Notably, while Deming regarded extrinsic rewards as counterproductive, others have attempted to combine the humanistic philosophy of quality management with substantive rewards. Several authors have also drawn attention to another paradox underlying the discourse on quality: despite the focus on empowerment, teamwork and humanistic values associated with an organic model of organization, the emphasis on process analysis and standardization is close to a Taylorist mechanistic model. The difference is that under TQM, employees programme their own work rather than having it programmed for them (Spencer, 1994).

Despite differences, the two techniques share certain common assumptions (see also Vinzant & Vinzant, 1996). First, they are both based on a functionalist view of organizations: common unified goals can be identified and organization members are motivated to find the best way to meet them to ensure the organization's survival. Both techniques propose analytical procedures for determining solutions based on an assessment of environmental demands and organizational capabilities, where the environment is defined mainly in terms of meeting market requirements. Both also assume that the organization (or work team in the case of quality management) has the autonomy to make and implement its choices. Moreover, both assume that leaders have sufficient power to ensure that once plans or improved work processes have been formulated, implementation will follow.

However, as shown in Figure 2, there is a significant 'compatibility gap' between the assumptions underlying the two techniques (first and third columns) and the habitual functioning of hospitals in a publicly funded

system (middle column). The Figure draws particular attention to differences in assumptions about the power distribution among key actors and the dominant forces driving organizational activity for the two techniques and for the organizational form studied. Essentially, rationalistic tools designed for a market-dominated environment are being applied in pluralistic organizations where market forces are diffuse and institutional forces (government bodies, etc.) are crucial. Below, we will elaborate on these differences, referring both to common features of public professional bureaucracies and, as pertinent, to more specific aspects of the Quebec health care context. While some authors have inventoried the features of 'publicness' (Rainey, 1991; Nutt & Backoff, 1992; Ranson & Stewart, 1994), others have noted the specificity of 'professional bureaucracies' in which highly qualified experts play an important role (Mintzberg, 1979; Hardy et al., 1984). As shown below, the specific institutional arrangements and resource allocation mechanisms existing in the Quebec health care system at the time tend to reinforce the classic portrait of the 'public professional bureaucracy'.

The top half of Figure 2 considers the compatibility gap in terms of two dimensions of relations with the external environment. First, the patients or 'customers' defined as the driving force in the quality management model and as a major determinant of strategy in the strategic planning model are weak in a public hospital. Patients lack power partly because they do not pay directly for services consumed. Indeed, in Quebec, they are an expense, not a source of revenue for hospitals which receive global budgets from tax revenues independently of services offered. Also, patients generally have insufficient knowledge to evaluate the quality of complex health services, and they are in a vulnerable position when they require treatment (Evans, 1984). Their choices are limited, particularly in an over-loaded system (Lozeau, 1997).

Second, in contrast to the assumptions behind the techniques, the public hospital's ability to decide autonomously which markets to serve and how to serve them is highly circumscribed. In Quebec, the Ministry of Health and Social Services and the Regional Board are the main agencies composing the organization's environment, playing to some extent the role of surrogate customers as hospitals compete with one another for funding and approval of major decisions. Professional associations, unions and accreditation agencies impose additional constraints.

The lower half of Figure 2 focuses on the compatibility gap in terms of internal dynamics. Here, the rationalistic approaches of strategic planning and quality management that assume unitary leadership, common goals and the ability to decree implementation contrast sharply with the fragmented leadership, diffuse power and multiple goals (patient care, cost control, etc.)

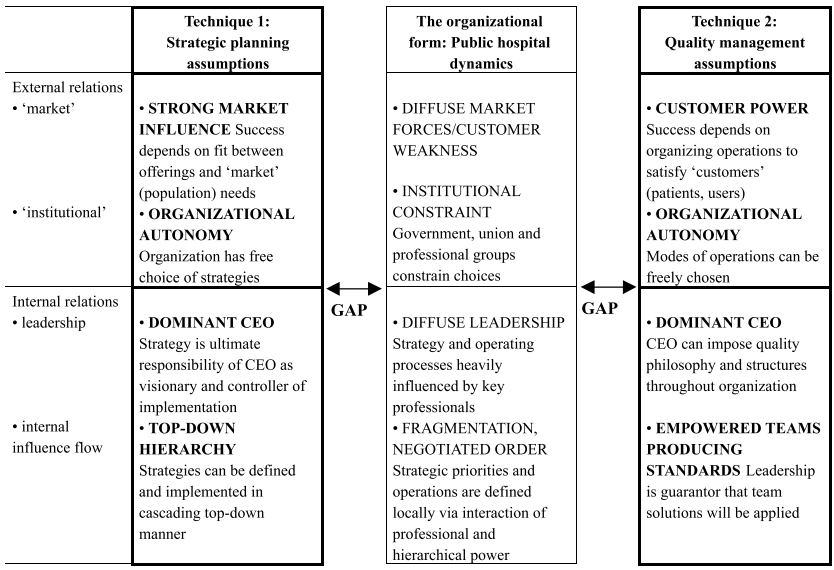

Figure 2 The compatibility gap: Assumptions of techniques vs. organizational form

of the public hospital (Freidson, 1970; Mintzberg, 1997). Hospital governance structures have been variously described as dual hierarchies (Freidson, 1970), three-legged stools (Johnson, 1979) and recently, as composed of four worlds (Mintzberg, 1997) each pulling in different directions. In Quebec, collective leadership roles are established by law and involve an elected Board, an appointed CEO and elected physician representatives (Denis et al., 1996).

The roots of this pluralism and ambiguity lie in the nature of professional work (Friedson, 1970; Mintzberg, 1979; Abbot, 1988) which demands that those with the knowledge to carry out the complex operating tasks have the autonomy to make appropriate choices. Physicians thus acquire considerable power. In Quebec, this power is enhanced by the fact that they are not hospital employees but are paid on fee-for-service basis by a separate government agency. At operating levels, physicians are clearly dominant members of the clinical group (including nurses and other professionals) who determine modes of patient care (Abbot, 1988). At the strategic level, their knowledge of developments in their field, their role as key resources and their autonomy make them important players. Their cumulated operating decisions have a direct impact on the organization's activity profile. Moreover, their advocacy of new clinical developments and their political skill in obtaining support for them are key determinants of strategic

choices. As analytic techniques oriented towards market-based rationality, strategic planning and quality management intrude into a politicized context that appears to function on entirely different principles.

In other words, the 'compatibility gap' seems large for both techniques. We now examine how this gap was handled in practice for our sample sites using the four scenarios introduced earlier for comparison. For each technique, we first identify the dominant patterns of adaptation and then explore a number of 'outlier' cases in which the trend was somewhat different. These special cases are useful in understanding how managerial techniques might contribute to broader change.

Handling the gap in practice: Case 1 – strategic planning

Only two of the 26 sites that claimed to have implemented strategic planning appeared to involve forceful attempts at 'transformation' (changing the organization to fit the model behind the technique) – one of these being quite successful, the other much less so. One site could be seen as a case of 'customization' in which the organization adapted the technique while modifying its internal functioning to match aspects of the theory behind it. These are our 'outliers'. The remaining hospitals appeared to combine elements of 'loose-coupling', where planning activities were detached from true strategic decision making, and 'corruption' in which planning processes were captured and reformulated to match the political mode of strategy formation characteristic of this organizational form. We now illustrate our observations in more detail beginning with a descriptive portrait of the dominant patterns, and then exploring the outliers.

Dominant patterns: Co-optation and loose-coupling

The evidence supporting our claim that strategic planning is most often either loosely coupled from organizational dynamics or essentially captured by them is summarized below. The basis for our assessment includes content analysis of plans, and respondent reports on the stimuli behind adoption of the technique, the processes used and the outcomes obtained (Denis et al., 1995).

Plans as promotional documents aimed at institutional actors

The following observations provide evidence of the widespread use of strategic plans as tools for promotion with respect to the institutional environment:

- All but one plan was freely distributed to the public. Many had glossy covers.
- Most hospitals formulated their strategies using the word 'recommendations' rather than 'strategies' and many of these 'recommendations' lay outside their control.
- Written plans were vague, wide-ranging and strongly oriented towards development. The 19 plans obtained had an average of 35 recommendations each. Content analysis revealed that 40 percent of these were oriented towards developments requiring new funding, while less than one percent involved cuts, despite a context of reduced resources.
- Sixty-five percent of hospitals indicated that mimetic or normative forces contributed to their adoption strategic planning: 'We wouldn't look good if we didn't have a plan'.
- Two hospitals had been required to produce strategic plans by an accreditation agency. Consultants were hired and a document was produced but the value of the work was widely questioned: 'It was a smoke screen just to let the CEO say we have a document'.

In summary, planning shows little sign of assisting these organizations in choosing between alternatives or in positioning themselves within their markets as the theory and its promoters claim it should (e.g. Peters, 1985; Bryson, 1988). Instead, plans are serving as a tool in negotiations with the institutional environment represented mainly by government. The more superficial applications of planning (e.g. the 'smoke screen' of the last quotation) illustrate the loose-coupling scenario. A more common approach was to find in planning some more proactive role (e.g. the promotion of professionals' aspirations for development). However, this role essentially reproduces existing external power relations. Rather than serving as an instrument of change, the technique is co-opted (or corrupted).

Planning processes dominated by negotiations among professionals

The same phenomenon is observed when the internal dynamics surrounding planning are considered. A frequently offered justification for planning was that it would generate some consensus, legitimacy and support around chosen priorities: 'The CEO wanted to mobilize the medical staff . . .'. Doctors were therefore invited to participate in large numbers (on average, 45 percent were consulted in some way). In parallel, 77 percent of hospitals undertook an analytical study of their external environment, often using an external consultant.

Obviously, it is the analytical aspect of strategic planning that should, according to the theory, be dominant in decision making. However, given the wide physician participation and continuing power, political negotiations tended to predominate. Among our respondents, 54 percent said that professionals' opinions counted more than analysis, 31 percent said analysis and opinions were equally weighted and only 14 percent felt that analysis dominated. One respondent argued that the analytical element of planning could be useful for challenging the views of people with vested interests: 'These statistics forced people to think. . .'. Yet, he later noted:

> Officially, quantitative data dominate . . . but in practice its was the qualitative data . . . and in the two hospitals where I was involved, there were political games that influenced the choices in the end that were not necessarily in agreement with the objective data.

The balance of power among medical staff may thus shift a little under the weight of negative data, but that power remained critical in shaping the emerging consensus.

The result was that professionals and administrators were able to get together to debate issues and to build some solidarity around the promotion of the organization with government. But in practice, the emergent 'consensus' rarely had any teeth. This was reflected in the large number of developmental recommendations noted, and also in the striking vagueness of their formulation (e.g. 'become more active in promoting', 'consolidate', 'consider the possibility of . . .' etc.). Fundamentally, it is easier to agree on a text when things are not spelled out clearly and when there is something there for everyone (Cohen & March, 1986).

Thus, again we see the nature of planning captured and transformed by the dynamics of the organization rather than the reverse. It becomes yet another tool of influence for managers and professionals within the diffuse power structure, rather than a path to 'rational' strategic choice. Moreover, when plans are vague and ambitious with few actions named and no budgetary data attached, the potential for controlled implementation is limited (see also Vinzant & Vinzant, 1996). Some strategies *were* implemented but action was often difficult to impute unambiguously to the plan: 'We would have done the same things . . .'. Other things were done that had not been planned as professionals pursued their entrepreneurial careers as before. Organizational dynamics were not and could not be changed by the imposition of a mere formal procedure . . . or could they? We now examine some exceptional cases that bucked the trend.

Outliers: Transformation and customization

Aborted transformation: A new CEO swimming against the tide

The first outlier illustrates what can happen when a leader overestimates his or her power, using strategic planning as a tool for transformation in an unpropitious context (Denis et al., 1996). A new CEO from a small organization arrived in a larger hospital with a powerful medical establishment, and a tradition of high volume and lucrative clinical practice. His diagnosis was that quality had been neglected to sustain volumes, that some specialties were weak and that patient needs might best be served by an alliance with another hospital. He hired consultants to start a planning process that would produce fundamental change. However, his behaviour reflected power assumptions associated with the traditional strategic planning model in a context where this model did not fit. The physicians reacted strongly, accusing the CEO of intruding into clinical areas that were not his business. They persuaded the Board to pull the plug on the planning effort, leaving the CEO in a severely weakened position.

Successful but temporary transformation: Planning in crisis

The second outlier concerns a hospital in crisis. The previous CEO had left under a cloud, and some members of the medical staff had been criticized by a professional body for the quality of obstetrical care. The hospital was placed under government trusteeship. The trustee became CEO, replaced the administrative team, worked with a new Board to make major changes and developed a strategic plan. The need to close obstetrics and find a new mission became evident. The CEO was able to ensure implementation of his plan with the help of a consultant, a physician administrator and the Board. As in the first outlier, the CEO behaved in a way consistent with the assumptions of the traditional planning model. Unlike the first case however, the compatibility gap was smaller because of the extreme weakness of the physicians as well as the unqualified support from the Board and the medical administrator. This top-down approach did not remain viable for more than two years, however, because as soon as competent physicians had been hired, they would no longer allow the CEO to play such a dominant role in strategy making. The 'transformation' was temporary to deal with unusual circumstances.

Customization: Planning as part of a new negotiated order

The third outlier is the most interesting. It was the only organization in our sample in which planning could be said to be truly institutionalized. The

hospital had over a period of 20 years fundamentally changed its behaviour adopting a 'planning culture' that involved the wide acceptance of formal analysis as an input to decisions and the use of plans in all areas as both determinants of action and control devices to measure progress. In 1995, it was working on its fourth five-year plan. Since the early 1980s, it had regularly updated organization plans, facilities plans, information systems plans and annual capital budget development plans. Moreover, unlike its peers, it consistently avoided budget deficits. It never used over-spending as a financing strategy but rather invested in efficiency improvements to free up funds for development.

At the same time, the modes of planning it used were idiosyncratic. For example, it designed its processes in-house rather than using consultants. Like other hospitals, it adapted them to permit extensive participation. However, more than elsewhere, participants seemed to look to management as a source of ideas, as a final arbiter and as an assurance that they would receive a fair hearing. Strategic decision-making mechanisms had reached the point where a senior doctor could say: 'I like the way decisions are taken here. Because even if you don't agree with them, there's at least some intelligence brought to bear'. It appeared that shared values of procedural justice partly based on rational choice, but also based on peer review routines had taken hold. This pluralistic but analytic model of decision making can be related to the ideal of collegiality sometimes invoked in classic visions of professional organizations (Satow, 1975; Hardy et al., 1984). This mode of operation was not without faults. The organization was very bureaucratic. However, more than others we observed, it had created a negotiated order that reconciled the pluralism of professional work with a preoccupation for efficient and integrated management. This was not achieved instantly, but through persistent incremental efforts by the CEO over many years. It is interesting to note that he was the first to initiate strategic planning in Quebec, at a time when it was viewed with suspicion by government. The hospital was a leader, not a follower of institutional trends. This unusual pattern was also perhaps helped by a certain solidarity among professionals who had chosen to work with a particularly sensitive type of patient.

To conclude our strategic planning case study, in the rhetoric used to promote the technique in the public sector (e.g. Peters, 1985; Bryson, 1988), the goal of transformation is often expressed. Planning is expected to make organizations more responsive to their markets, more 'rational', and better able to establish and implement shared priorities instead of developing in a 'haphazard' manner. Government bodies and accreditation agencies latch onto these objectives and encourage the formal processes associated with them. Yet our data suggest that for such transformation to occur, markets or

populations must be powerful and managers must be able to force strategic decisions. This does not fit the power distribution in most hospitals except perhaps in times of crisis. This leads to a pattern of strategic planning adoption in which the objectives of the technique are perverted. Rather than planning changing the organization, the organization changes the technique into a tool that reproduces its previous mode of operation. However, the analysis of one outlier case suggests that a different outcome may be possible in which pluralistic and analytical perspectives are better reconciled. Yet such an approach seems to require long practice, a propitious context and exceptional consistency from management.

Handling the gap in practice: Case 2 – quality management

We now replicate the analysis of the previous section focusing on a different technique introduced several years after strategic planning: quality management. Again, our data suggested that the loose-coupling and corruption scenarios tended to dominate.

Dominant patterns: Co-optation and loose-coupling

Quality management programmes directed at satisfying institutional norms

Overwhelmingly, the quality management programmes we observed had been introduced in response to institutional pressures represented mainly by the Canadian Council for Hospital Accreditation (CCHA). Although it was not strictly mandatory to be accredited, it was important for any hospital that wished to establish its reputation. The CCHA formulated standards concerning the form and content of quality management programmes. To be accredited, hospitals had to conform to these norms (a kind of 'coercive' isomorphism, DiMaggio & Powell, 1983).

For most hospitals then, the quality management effort was driven more by the need to satisfy the CCHA than by pressure to satisfy customers whose power in the public hospital system was, as we noted, weak. One symptom of this was the sudden increased intensity of quality activities six months prior to an inspection with sharp fall-off afterwards. The drive to satisfy the CCHA also determined the content of the programmes, which tended to focus on documentation of procedures rather than actions to improve care. The CCHA thus became the hospital's surrogate 'customer'. However, the link between the capacity to obtain accreditation and customer satisfaction was tenuous given the infrequent and short inspection visits. The

hospital's mode of transaction with its environment was thus not significantly altered.

Quality programme activities that reproduce existing internal power dynamics

Even where leaders might buy into the quality philosophy, the diffuse power structure meant that this philosophy could not easily be made to infuse the entire organization, especially in the absence of strong pressure from customers. Implementation according to strict TQM principles would have involved transferring power from top and middle managers to lower-level employees, and from dominant professionals (physicians) to teams. Politically, no one was in a position to impose such a transfer other than at the margins. Rather than attempt this, managers adopted a range of strategies that allowed them to satisfy the requirements of the CCHA and perhaps promote the need for quality, without confronting the existing power structure.

For example, to provide the documents required by the CCHA, it was expedient to centralize activities around a single individual – often a staff person from nursing. The role was attractive to nurses as it valued their expertise. However, the use of a staff person from a lower status group ensured that this would be a low-level preoccupation for managers and physicians, allowing them to keep their distance, and enhancing the focus on form rather than substance. Indeed, although several quality co-ordinators claimed that they eventually intended to get physicians involved, none had so far done so despite the fact that physicians are the prime actors in determining work processes as they affect 'customers'. This was not a case of overt resistance. Rather, quality staff seemed to assume (probably correctly) that doctors would not agree to participate and that it was therefore useless to try: 'Perhaps we didn't try hard enough to get them involved'.

With mitigated support from senior managers and physicians, some quality programme co-ordinators attempted to approach employees directly. The common experience was however that quality teams often focused more on problem-solving that removed employee irritants than on issues that had a major impact on customers. One team for example explained proudly how they had improved the work environment by installing a glass screen between them and the patients.

This illustrates again how the quality management technique has been altered as it penetrates the organization and how organizational dynamics have remained relatively untouched, with quality serving as yet another political football harnessed by various individuals in various ways, and

leaving patients on the sidelines. Though accreditation was obtained in most cases, the transformational power of quality improvement is not manifest here.

One interpretation of events is that there exists a kind of tacit agreement among the CCHA and top managers (CEOs) and between CEOs and other employees in which all suspect that the activities practised are superficial but perpetuate ritualistic manifestations of quality management to avoid confrontations that would not be in their interest (Lozeau, 1997). The CCHA checks up on hospitals but its processes provide ample warning and allow hospitals time to put on a good show. CEOs pay lip-service to CCHA norms and provide adequate evidence to support positive evaluations. Simultaneously, CEOs promote quality management with employees but do this in such a way that existing power structures are not threatened. Reports of quality activities that exaggerate their success are given cursory review and activities that were not really part of the quality effort are accepted as evidence of success. Lower-level managers avoid overt opposition, going through the motions of conformity rather than risk sanctions. In the process the very idea of quality management has been perverted. However, considerable energy has been expended.

An outlier: Customization

Our study produced a poor harvest in terms of observing even limited change as a result of quality management implementation. Reports in the literature lead us to believe that while the pattern we have described as dominant is indeed common, there *are* examples in public hospitals where some form of transformation or customization may have occurred. We remain however prudent, given our own disappointment when two much-touted success stories were subjected to systematic observation. What we found from the studies of Alpha and Omega was that the real 'successes' tended to be localized in one or two departments. These events were then blown up to create a wave of rhetoric that was out of proportion with the actual achievement. We found no sites where quality management had become a driving philosophy as described by its theorists. We will nevertheless describe the most remarkable of the local success stories we uncovered.

Customization: Creating a quality-driven island

The example comes from the housekeeping department of the Omega site, an area that has little contact with patient 'customers' but one where it was possible to define 'internal customers' following the logic propounded by

several quality gurus. The department head became enthused with the quality philosophy shortly after taking his job. At the time, the department appeared chaotic, having no systematic procedures and reacting only when it received complaints. The new manager saw the promotion of the quality approach as a career opportunity for himself and also as an opportunity to add value to his low status function and to improve the self-esteem of the employees who worked there.

He began by holding meetings with employees. The first decision was to change the negative sounding name of the department. He then moved to job enrichment, sending employees to suppliers to learn about their equipment, and promoting the department within the hospital. This gave him a high profile and increased his team's satisfaction and the quality of service. Rather than following the hospital's rhythm in implementing quality instruments, he introduced his own ideas as they seemed appropriate. Indeed his team became a role model. Ironically, the efforts of this small department lay at the root of the organization's reputation as having successfully implemented quality management. In truth, it was an idiosyncratic island in an organization that had not truly integrated the philosophy (Lozeau, 1997).

This exceptional case occurred in a part of the organization that is perhaps most like a traditional manufacturing firm, and in a place where the leader had clear hierarchical authority. It occurred for an activity that had internal clients but no significant internal suppliers. In other words, it was an autonomous unit that did not have to develop complex relationships across professional groups. It was a small business within a complex professional bureaucracy with a 'CEO' who was intrinsically motivated to implement quality management.

Would it be possible to develop a form of customized quality management in the clinical domain? For this is to occur, the intrinsically motivated leader would need to be highly credible: probably a physician. We saw no inclination among doctors to diverge from their traditional technical conception of quality, but evidence from other studies suggests that when physicians do become enthused by the approach, they can make a difference (Carman et al., 1996; Weiner et al., 1997). Nevertheless, where clients are weak and interests often lie elsewhere, creating such enthusiasms is a hit-and-miss occurrence depending on individual altruism and entrepreneurship.

In summary, many of our observations concerning the strategic planning case also apply to quality management. Both techniques tend to be captured by the organizational dynamics into which they are inserted rather than transforming those dynamics in any fundamental way. In terms of outliers, the quality-driven island is similar to the crisis-driven planning situation in the sense that within the limited boundaries of the situation described, the

'theory' of the technique described in Figure 2 has reasonable validity. Beyond those boundaries, the confrontation of 'rationalistic' technique and pluralistic organization becomes intense and 'rationality' (at least of the top-down goal-directed kind) tends to quickly fall by the wayside.

Discussion and conclusion

This research examined how managerial tools such as strategic planning and quality management impact on and interact with complex pluralistic organizations, in particular publicly funded hospitals. We have shown that these techniques appear to be blunt instruments for change. Yet, institutional forces are pressuring such organizations to adopt the techniques, and because of this, they *are* being adopted, often with considerable expenditure of resources. However, as we demonstrated, their role is transformed as they are captured by the very dynamics that they were intended to change. We now analyse the implications of these findings from two perspectives: an 'outcome perspective' in which our observations of 'corruption' are interpreted as 'failure' to be corrected; and second from a 'process perspective' in which 'corruption' is interpreted as a *process* of social construction within the ongoing dynamics of institutional and organizational evolution (Greenwood & Hinings, 1996). We argue that this process-oriented understanding is richer and could help to promote more informed modes of intervention.

Outcome perspective: Corruption as failure

The most direct interpretation of our results is that in most cases, strategic planning and quality management simply 'failed'. The question then becomes, how could failure be avoided? The answer will be different depending on whether one believes that the root of failure lies with management, or with the techniques themselves. The first position represents a 'managerialist' view (Pollitt, 1990) in which the transfer of techniques between sectors is seen as desirable though perhaps difficult (e.g. Berwick et al., 1990; Nutt & Backoff, 1992), while the second position sees sectoral transfer as often ill-advised and even potentially destructive of professional and public service values (Ranson & Stewart, 1994; Haque, 2001).

Corruption as failure of management

An expression of the first position is revealed strongly in a recent analysis of TQM in the NHS (Nwabueze & Kanji, 1997: 277). The authors made empirical observations similar to ours and concluded that managers showed

'a lack of conceptual understanding of the holistic requirements of TQM'. The authors go on to urge NHS managers to invest in a series of 'critical success factors' including 'an organizational structure sympathetic to TQM', 'leadership, commitment and vision from top management', 'a holistic approach that involves everyone, particularly clinicians' and rewards for 'accomplishments and exemplary service in the provision of patient care'. They add: 'Hospitals should be given the leverage to fire uncooperative clinicians'. Fundamentally, the authors are arguing for a remodelling of the entire organization in the image of the technique including changes to structure, power and incentives. Judging by our own observations, they may be right that this is the only way in which TQM could be implemented in its pure form. However, the proposed prerequisites seem so demanding as to preclude progress since they, like the technique itself, would have to be negotiated and implemented through the organization's current political system. As illustrated by one outlier case of transformational strategic planning, such an approach appears destined to meet with strong resistance and thus 'failure' of a different and perhaps more costly form. The fundamental paradox of the 'critical success factor' argument, dominant in much of the literature (Bryson, 1988; McLaughlin & Kaluzny, 1990; Vinzant & Vinzant, 1996) is that the techniques apparently work best where they are least needed, i.e. where the context is compatible and therefore already working in a way close to that projected by the theory of the technique. Generally, implementing the 'critical success factors' constitutes an even greater challenge than the technique itself. This leads to a serious impasse.

Corruption as failure of technique

The alternative position would be to argue that the failure lies not with management or organization but in the techniques themselves. From this viewpoint, the attempt to apply strategic planning and quality management in public hospitals is illusory and destructive. As we have seen, the energy costs can be high, and the contradiction between the norms represented by the techniques and the practices actually developed is so evident that one cannot be taken for the other. Yet organizations and people within them seem to be caught in a system of institutional constraints where they must pretend that the two are the same. This is hypocrisy, and hypocrisy breeds cynicism, surely a destructive force. Cynicism is enhanced by the rapid replacement of techniques over time, leaving employees increasingly de-motivated and less likely to collaborate next time.

This diagnosis might lead to the conclusion that accreditation bodies should not impose processes that are incompatible with the nature of the organizations they are regulating. One could argue that professional

organizations have their own 'rationality' different but no less legitimate than the market-based rationality of the techniques. In this view, patients are *not* customers and that is the very reason why professions exist: to protect their interests in situations of dependence and information asymmetry (Evans, 1984). Professions have their own quality norms supported by intense training and peer-review. Quality management may be a redundant overlay on these processes that reduces professionals' autonomy to make decisions in the best interests of patients (e.g. McLaughlin & Kaluzny, 1990; Pollitt, 1993). One might also argue that strategic decision making *should* be based on the judgement of experts, rather than on the calculations of managers detached from operations (Mintzberg, 1979).

And yet, this position is simplistic too. While one may appreciate the professional and public service values traditionally associated with professional bureaucracies and the public sector, it is hard to ignore the fact that these organizations have often appeared unresponsive to public needs (Pollitt, 1990; Rainey, 1991). It sometimes seems as if power is shared widely between almost everyone except the people for whom the health care system exists (Rochon et al., 1988). Most observers agree that there are indeed real problems to be solved. However, our analysis suggests that the answer does not lie in imposing a formal procedure designed and promoted on the basis of its success at IBM, Walt Disney or Xerox (a real example).

The arguments and data *do* suggest a need to invent management techniques that make sense in their own context. The outlier strategic planning 'customization' case indicates that there may be potential to promote a form of 'collective' or 'collegial' rationality that can offer improvement in service and performance, but that is not incompatible with the nature of public hospitals (Satow, 1975). However, the conditions for its existence seem fragile and as we saw, its implementation is not a short-term project. There is room for more research to examine what forms this alternative rationality might take. It is important to note, however, that a 'customization' solution generates managerial processes that are organization-specific. The more that this is true, the more the labels of the popular literature (planning, TQM, CQI, BPR) will be inappropriate to describe 'good management' in these organizations. Unfortunately, if regulators continue to evaluate organizations according to the orthodoxy of their processes, they may not recognize incidences of 'good management' when they see them.

Process perspective: Corruption as social (re)construction

The above analysis situates our study within the debate over the appropriateness of sectoral transfer, but provides a somewhat static interpretation of

the findings. The focus is on outcomes ('success' or 'failure') with little attempt to understand the underlying *processes* set in motion. In the following discussion, we return to the theoretical frame. We argue first that the fundamental dynamics we observed are generalizable to a variety of managerial innovations in a wide range of contexts. Second, we situate the impact of specific techniques within a dynamic flow of continuous organizational and institutional change. Finally, we argue for a mobilization of this 'process' understanding to find new ways to improve management interventions.

First, our observations can be seen as manifestations of general processes in which deliberate attempts to alter interaction and behaviour patterns must always be implemented and negotiated through prior accepted modes of interaction and behaviour – or what Reed (2001) has called 'positioned practices'. These 'positioned practices' are structured by existing power relations, interests and values inside and outside organizations (Ranson et al., 1980; Reed, 2001). In other words, the shape of change is always socially (re)constructed by the people who take part in it.

Similar observations have been made by other researchers examining institutional change in professional services and the public sector. In the context of accounting firms, Cooper et al. (1996) labelled this process 'sedimentation' because of the way in which social reconstruction of new institutional ideas tends to produce hybrid arrangements that reflect the layering of new ideas and values onto older organizational forms rather than their replacement. Related phenomena have been observed in law firms (Gray, 1999; Morris & Pinnington, 1999). Kitchener (1999) observes similar confrontations of values in the implementation of quasi-markets in UK health care, as well as in US hospital mergers (Kitchener, 2000). Ferlie et al. (1996) also describe the emergence of hybrid forms following implementation of 'new public management' reforms in the UK. In these cases, the authors look not so much at a specific technique, but at broader institutional trends in which the legitimacy of traditional professional and public sector organizational forms is being contested, and new 'organizational archetypes' are emerging based on different coherent sets of practices and values (Greenwood & Hinings, 1996). The emphasis on 'managerialism' and 'business-like' practices seems common to these changes (Brock et al., 1999: 223). Yet the multiplicity of ideas available, (Ferlie et al., 1996), the constant stream of reform and the resilience of existing positioned practices is creating considerable ambiguity about the ultimate shape of any new 'archetype' (Brock et al., 1999).

There are also parallels between our analysis and that of researchers examining the role of management tools in very different types of organizations. Compatibility gaps may exist anywhere. In particular, Knights and

McCabe's (1998, 1999) work on the implementation of business process reengineering (BPR) and TQM in financial services demonstrates how the political context within these firms interacts with managerial techniques. Both the empowerment discourse of TQM (Knights & McCabe, 1999) and the 'apolitical' discourse surrounding BPR (Knights & McCabe, 1998) are seen to be profoundly at odds with the context in which they are applied. On one level, the result is 'resistance'. At a deeper level, the authors note that the techniques are simply yet another occasion for the playing out of organizational power relations. In this process, the formal techniques are transformed and reinterpreted ('corrupted'), while the power dynamics of the organizations themselves are largely, though not perfectly, reproduced.

It is in these imperfections that the real potential for change lies. Our second point is that any managerial innovation must be seen within an ongoing stream of activity. Change is dynamic and cumulative. The outlier 'customization' case of strategic planning we described is not really the story of the one-time implementation of a particular technique, but the story of a cumulative change process in which local imperfections in the reproduction of political dynamics and shared understandings at one time period were skilfully mobilized to consolidate further change later. Within such a process of ongoing change, certain interventions appear to have stronger potential to transform organizational dynamics than others. For example, interventions that redistribute resources or that fundamentally restructure incentives and interests (i.e. altering what powerful people are likely to want) appear more likely to influence behaviour. Yet even here, the changes may be reconstructed and interpreted in unexpected ways (Whittington et al., 1994; Giacomini, 1998). Moreover, the decision to make these changes also has to be negotiated through some of the same political dynamics and 'positioned practices', though perhaps at different levels.

Formal techniques based on purely procedural change (such as strategic planning and quality management as observed) appear modest in their capacity to redistribute power and alter patterns of interests, and are thus particularly prone to 'corruption'. Yet they may still pave the way for deeper change as people participate in them, and become increasingly socialized to the values they represent (Oakes et al., 1998). Earlier attempts at bureaucratic reform within the NHS and UK public service were seen as having limited impact (Ackroyd et al., 1989; Pollitt, 1990). It was only when more radical restructuring mechanisms began to interact with professional and bureaucratic modes of operation that more substantial change was observed (Ferlie et al., 1996). Similarly, the implementation of strategic planning and quality management in Quebec hospitals preceded and presaged the more structurally significant health care reforms of the late 1990s.

Our final point is that if one understands how and why techniques are socially reconstructed in the course of ongoing interactions, herein lies a way to rethink management intervention that reaches beyond the impasse we noted earlier. We have seen that the theories behind many management techniques are largely incompatible with 'positioned practices' in public hospitals producing corrupted processes that enable legitimation, but that often consume resources for marginal benefit. An alternative might be to turn this approach on its head and ask what kinds of coherent normative theories (or alternative 'rationalities') might have potential to move a specific organization in fruitful directions (e.g. in terms of strategic autonomy, or in terms of patient care), taking into account the fact that they must inevitably be negotiated through existing power relations, values and interests. Perhaps managers, regulators and professionals need to find and legitimize their own 'techniques' based on their own theories of organizational performance, rather than borrowing and bastardizing techniques from elsewhere. Given the current ambiguity concerning the ultimate shape of professional organizational forms, perhaps there is also room for promoting 'reflexivity' (i.e. thoughtful management that eschews packaged solutions) as the next management fashion (Abrahamson, 1996; Gray, 1999).

Acknowledgements

The authors are grateful to the participants in this research for their interest and collaboration. Thanks also to the three reviewers and to Martha Feldman, Barbara Townley and Mark Zbaracki for comments and discussion at the 1998 Academy of Management Meeting in Chicago. Finally, we thank the Fonds FCAR and the Social Sciences and Humanities Research Council of Canada for their financial support.

Note

1 The description of planning provided by Mintzberg (1994) is exhaustive, though provocative, emphasizing the weaknesses of the analytical approach to strategy formation. This position engendered a debate between Mintzberg (1990, 1991) and Ansoff (1991). However, despite disagreement over the efficacy of planning, Ansoff does not contradict Mintzberg's (1988, 1990, 1994) formulation of the premises behind it, even implicitly reinforcing them in his own arguments.

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