The New National Health Service: A Case of Postmodernism?

Mike Dent

Organization Studies 1995; 16; 875
DOI: 10.1177/017084069501600506

The New National Health Service: A Case of Postmodernism?

Mike Dent*

Abstract

The National Health Service in Britain has recently undergone a major reorganization. It has moved away from being a planned system of health care delivery to a demand driven system organized on the principles of (quasi-) market competition and quality assurance. These changes are intended by government to 'empower' the consumer (patient) with real choice and to incorporate the health professionals within a more effective and efficient system of hospital management. It is in this context that the paper examines the usefulness of 'postmodernity' as an explanation for the emergence of new 'flexible' organizational forms within the hospital service. The paper will concentrate on the ideological and organizational contradictions between state policy and local practice, especially in relation to issues of managerial vs professional autonomy and control.

Descriptors: postmodernism, new organizational forms, National Health Service, public sector, internal markets

Mike Dent
School of Social Sciences, Staffordshire University, Stoke on Trent, U.K.

Introduction

This article addresses the question of the utility of postmodernism for either the analysis or understanding of contemporary organizational restructuring. Specifically, the article examines whether the new organizational arrangements, based on a concept of an internal market, currently being implemented and evolving within the National Health Service (NHS) in the United Kingdom are evidence of what some have termed postmodernism. The interest in focusing on a public sector organization is that, in contrast to the private sector, the changes are the result of conscious political choice. This gives rise to particular ideological and organizational contradictions between state policy and local practice, especially in relation to issues of managerial vs professional autonomy and control.

The article starts with a general discussion of postmodernism and organizational analysis. This is followed by a section on the recent organizational changes within the NHS hospital service in the United Kingdom and the ideological and organizational contradictions inherent within them, which leads into a consideration of how the restructuring

Organization Studies
1995, 16/5
875–899

0170–8406/95
0016–0031 $3.00

might be best understood. It is here that the issue of postmodernism is explored, and it is done so in relation to the post-Fordist interpretation of these changes. Having established my own position on the matter, I then proceed to a specific case study which has every appearance of being an exemplar of a post-bureaucratic hospital. This is followed by a short conclusion.

Postmodernism and Organizations

Current debates surrounding postmodern organizations and organizational analysis can be broadly summarized as being either in terms of *epistemology* or *periodization* (Cooper and Burrell 1988; Parker 1992; Hassard 1993). The two are not mutually exclusive although they tend to be clearly separated within the debates in the United Kingdom (e.g. Hassard and Parker 1993).

Epistemology: What Is To Be Known?

Postmodernism is an assertion that the period of modernism has ended and that the Enlightenment project of emancipation based on human reason is at an end (Bauman 1992). We can now see, so the argument runs, that there are limitations to human reason and it is therefore futile to pursue any such utopian scheme (Bauman 1992). If this is the case, then organizational analysis is confronted with a major quandary as modern organizations are themselves products of human rationality. Weber's legal–rational bureaucracy was premised on the application of just such a notion, although he did not identify legal–rational bureaucracy with any emancipation or utopian project, if anything the reverse, in the form of an 'iron cage' and disenchantment (Albrow 1970; Eldridge 1973).

Postmodernism can be identified as having emerged, at least to significant degree, from post-structuralist discourse (Harvey 1989: 41). Particularly significant for organizational analysis are Foucault's ideas, especially his analysis of power/knowledge (Rabinow 1984: Harvey 1989: 45). There is, for Foucault, an intimate link between systems of knowledge (discourse) and social control, but only within specific localized contexts. One major aspect of Foucault's work has been his extension of Bentham's model nineteenth century prison, in which inmates are continually under the surveillance of the central inspection tower whilst in their individual cells and controlled by a rigorous disciplinary code (Foucault 1977). In the latter part of the twentieth century this model was extended to modern organizations more generally, utilizing computer technologies as the means of surveillance and control (Lyons 1988; Dent 1991).

Control, however, is not the issue with which the self-proclaimed postmodernists have been concerned. They have been more pre-occupied

with language. According to Lyotard (as an obvious example), all social activity is essentially a network of language games (Harvey 1989: 46). Within this framework, organizational analysis becomes more a concern with 'the production of organization rather than the organization of production' (Cooper and Burrell 1988: 106). Moreover, it is futile to seek to construct any organizational meta-narrative but rather to concern ourselves with the inherent instability of organizations and their structures. It is more accurate from this perspective to view organizations as the outcome of 'moves within a game' (Hassard 1993: 44) and not the outcome of overarching control systems/structures. Moreover, even the 'game' of analysis is driven by the contestability or 'agonistics' inherent in competitive games (Cooper and Burrell 1988: 98) and it is this alone that sets the limit to any organizational analysis. No grand theory is possible and the discourses will themselves be rooted in dissensus. Consensus means the end of the theoretical discourse (Cooper and Burrell 1988: 99). It is in this connection that Derrida's contribution, according to Cooper (1989), can be located. It is Derrida's contention that any assumption concerning the processes of rationality serve only to obscure the uncertainty which lies at the core of any social action (Cooper and Burrell 1988; Cooper 1989: 488–489). Instead, one must identify the internal contradictions within these discourses by a process of de-construction (Derrida 1978, 1981). The process of analysis is based on 'overturning the hierarchy at a given moment' and then stabilizing the analysis by metaphorization (Derrida 1981: 41, quoted in Hassard 1993: 30).

The postmodern epistemology as applied to the sociology of organizations is less of a 'rupture' than some might claim. Phenomenology and the privileging of language and language games has long been an important strand in sociological and organizational thinking, with much of the influence emanating from the work of Wittgenstein (Burrell and Morgan 1979: 254–255). What is distinct about the current postmodern discourse is the growing tendency to equate ontological uncertainty with organizational flexibility. Previously, the discourse was concerned with issues of 'efficiency' and 'effectiveness' (Albrow 1970) and flexible — organic — forms were considered more a management strategy of giving up control to keep control (Burns and Stalker 1961; Fox 1974). In practice, these remain major concerns of management. Now, so the argument seems to run, this involves the acceptance of new, more autonomous, organizational forms. It is to this issue of new organizational forms that I now turn.

Periodization: The Postmodern Epoch

At sometime in the 1980s there began to be a realization that the organizational forms that have dominated modern societies for the last 100 years were no longer appropriate, especially those characterized by hierarchy, centralized control systems and specialized division of labour

(Reed 1992: 226). The newer, more flexible, forms of organization identified as flexible specialization or post-bureaucratic (Heydebrand 1989) where beginning to be recognized as not simply modifications but more thorough-going transformations from the pre-existing Fordist and bureaucratic forms to neo-/post-Fordist, flexible specialist forms (Clegg 1990; Reed 1992). This transformation has been widely seen as a reflection of wider economic, social, political and technological changes within society. For Heydebrand, the emergence of post-bureaucratic forms 'are largely the result of the transition from industrial to post-industrial capitalism' (1989: 323). The general view, however, has been less sanguine, emphasizing more the result of an accommodation to the erosion of the West's privileged economic position and technological dominance *vis á vis* the rest of the world (Giddens 1987: 16). The reality for Western economies has been one in which the post-war settlement based on Keynesian economics, Fordist production and consensus politics has increasingly failed (e.g. Jessop et al. 1988; Lash and Urry 1987).

The movement towards post-Fordist flexible specialization (Piore and Sabel 1984) and its variants reflects more the 'end of organized capitalism' (Lash and Urry 1987), increasing globalization and the emergence of what Harvey has 'tentatively call[ed]' *flexible accumulation* (1989: 147). Within this new world order flexibility and innovation are crucial.

> 'It has entrained rapid shifts in the patterning of uneven development . . . . It has also entailed a new round of . . . "time–space compression" . . . the time horizons of private and public decision-making have shrunk, while satellite communication and declining transport costs have made it increasingly possible to spread those decisions immediately over an ever wider and variegated space.' (Harvey 1989: 147)

According to this version of postmodernity, *productionist* values no longer dominate the economic and political agendas; in their place *consumerist* ones have gained ascendance. A view that has some correspondence with Baudrillard's version of the shift from modern to post-modern society, and with it the imperatives of production, has been replaced by a new system of images and signs in which the distinction between the real and its representation is problematic (Baudrillard 1983; Smart 1992: 123–127). Baudrillard (1983: 154, n.4), following McLuhhan, views the 'medium as the message', i.e. an implosion of 'the medium' and 'the real', has occurred giving rise to a nebulous hyperreality which erases their differences and distinctiveness (Smart 1992: 127). This 'implosion' plays a crucial role in the mobilization of consumers. Moreover, consumer power has now become more crucial than labour power within cybernetic capitalism (Baudrillard 1975: 144 cited in Smart 1992: 121). The only certainty, it seems, is the uncertainty of the (world) markets. Changing patterns of consumption are closely related both to the growing ascendancy of post-modern tastes

and ideas (Bourdieu 1984; Featherstone 1991; Lash 1990) and to the changes in markets i.e. 'specialized consumption' and niche markets (Piore and Sabel 1984; Lash 1990: 39–40; Clegg 1990: 181).

For Lash, the change in consumption 'is in all likelihood cultural' (Lash 1990: 41) and marked by a shift from *differentiation* to *de-differentiation*. The latter term has something in common with the work of Baudrillard (Lash 1990: 5). The modernist tendency was towards *differentiation* (Lash 1990: 11–12). This is most directly reflected in organizational forms with a legal–rational ideal type of functional specialization. These functional distinctions are now being replaced, so the argument runs, by a post-modernist one in which modular, multi/inter-disciplinary teams replace functional hierarchies; a process of *de-differentiation*. We can see this also in the case of technology. With the introduction of digital technology, for instance, it is now possible to integrate previously functional distinct technologies e.g. telephone, fax, computers and CDs thereby de-differentiating between image, sound/music and text. The post-Fordist organization, whether or not it is postmodern, can be assumed to be highly dependent upon information and communications technology (ICT). As Heydebrand has hypothesized, such technology can '[open] the door to flexible and informal social arrangements in the workplace and to a post-hierarchical form of organization' (1989: 342).

I wish now to turn to the case of the National Health Service (more precisely, the hospital service) for it strikes me as a particularly 'interesting case' in that it has been a 'workbench' for new organizational forms intended to change health-care delivery from a professionally (*producer*) defined service to patient (*consumer*) defined marketplace. At least, that is the official rhetoric implied in the title of the 1989 White Paper *Working for Patients*, one of the key aims of which was to extend patient choice. The aim of the subsequent legislation (NHS and Community Care Act 1991) was to transform health authorities into 'champions of the people' with a duty to consult consumer interests closely (Ranade 1994: 71). These changes may, however, be less a commitment to consumerism than a simulacram designed for other more modernist purposes such as 'efficiency' and 'effectiveness'. It is to this general question that I now turn.

The U.K. Health Service as a Modernist Project

The NHS, it has been argued by the Labour politician, writer and journalist Michael Foot, is 'the greatest Socialist achievement of the [post-war] Labour government' (Foot 1973).

> 'It was the first health system in any Western Society to offer free medical care to the entire population. It was, furthermore, the first comprehensive system to be based not on the insurance principle . . . but on the national provision of services available to everyone . . . .' (Klein 1989: 1)

It has become the exemplar of what the modernist project could achieve. The organizational structure designed to deliver this service was highly bureaucratic. At the centre was, and remains, the Department of Health, the Minister of Health and Parliament. Next, there were 14 Regional Health Authorities for England which oversaw the work of 192 District Health Authorities. These bodies in turn were responsible for the organization of health services in their locality. Finally, there was the administration of each hospital. This is a very basic outline of the structure which has been, more or less, in place since the early 1970s. It is not my intention to present a detailed exposition of the organizational structures of the NHS. Both Ham (1985: Chapt. 1) and Ranade (1994: Chapt. 1) can usefully provide that information.

Despite the strong centralized structure, the balance of power has not been unambiguously in favour of the Department of Health (e.g. Ham 1985: 122). In fact, the reverse has often been the case. Parliament allocated resources, but it was the doctors who primarily decided how the monies were spent. Something like 80 percent of all health costs were (and probably still are) generated by doctors' medical decisions (Döhler 1989: 178). While the modernist principles of organizational rationality appeared to apply, doctors had always been able to rely on their professional autonomy to avoid carrying out policies with which they as a group did not agree (e.g. Ham 1985: 153–156; Dent 1994). This in itself did not undermine the modernist logic of the service. While professional autonomy injects an ambiguity into bureaucracy it has, nevertheless, been there since Weber (e.g. Albrow 1970).

The basic assumption behind the setting up of the NHS in 1948 was that new 'free at point of delivery/consumption' service would systematically clear up a backlog of ill health known to exist in the community (Ham 1985: 38). Thus the health service was an Enlightenment project, in itself designed to free the people from the burden of illness and disease. The premise, however, turned out to be false and the hospital service grew rather than shrank in size and complexity. By the 1970s the 'apparently inexorably increasing costs of all Western health services coincided with the end of an ''era of optimism'' about the contribution that high technology scientific medicine was making to health' (Elston 1991: 68). Even so, the acute services remain dependent on expensive high technology, despite increasing efforts to control and monitor new developments (Ranade 1994: 39). Another perhaps more central challenge to the health service is the 'greying' demography of U.K. society. As elsewhere in the West, Britain has an ageing population and older people require more health-service support than their younger counterparts and, for the most part, this age group do not require high-technology treatment (Ranade 1994: 33–36).

The medical dominance of hospitals (Freidson 1970), coupled with high-technology medicine and the changing demography, has put substantial organizational as well as financial strains on the NHS.

This is not a situation unique to the United Kingdom. Similar conditions exist in Europe and the United States. For example, see *The Milbank Quarterly's* volume on *The Changing Character of the Medical Profession* (1988), Freddi and Björkman's (1989) edited volume on *Health Governance* and, more recently, Johnson, Larkin and Sak's *Health Professions and the State in Europe* (1994). All these publications point to the dominant role of physicians in the organizational shaping of health-care delivery and the governmental pressures in many states to introduce mechanisms to constrain this role and thereby contain the cost of medical technology and services. This concern has concentrated the attention of many analysts (including those just cited) on the concept and issue of professional autonomy and the prospects of de-professionalization and/or proletarianization of doctors. Within the NHS, many hospital consultants have been incorporated within the new organizational arrangements as clinical directors, thereby avoiding erosion of their status whilst at the same time changing their professional role within the hospital division of labour (see Dent 1993). Whilst clearly relevant, this is not the central focus here. Rather the concern is with the growing centrality of market relations and the commodification of health services, this being the opposite side to the same 'coin' as the putative 'de-professionalization' of doctors. Whether the coinage is postmodern or of 'high', or 'late' modernism as one can imply from, for instance, Gidden's analyses of general social change (1990), cannot be answered yet. First it is necessary to identify in more detail what changes have actually taken place in the organization of the NHS hospital service.

From Hierarchies to Markets

Going to Market

The immediate rationality for introducing market mechanisms into the NHS has been essentially to control its escalating costs (e.g. Abel-Smith 1984) and, in the process, to erode the long-standing dominance of the biggest spenders within the NHS, the doctors. In the process the changes have, over a decade or more, eroded the general principle of the universal provision of services according to 'procedural rules' and replaced it with a more pragmatic one of 'getting things done' (see Heydebrand 1989: 343). Gone are the rational principles of planning and priorities within an integrated service. In their place has come the imperative of 'consumer' demand (the inverted commas are essential here) in an internal market of competing hospitals, clinics and general practice (etc.). The movement towards marketization, however, has not been in any sense a unilinear one.

The general strategy of the British Conservative administration has been

more heterogeneous than might be implied from the summary so far. This can be clearly shown with reference to the three major policy innovations:

1. *Griffith's Inquiry* recommended a single line of management supported by effective management information systems (1983; Scrivens 1988) to replace the consensus management introduced the previous decade.
2. The introduction of *Resource Management* (Department of Health and Social Security 1986) with the conscious management of meanings and symbols (culture) to incorporate medicine into management with their acceptance of financial constraints on their clinical activities.
3. (a) The White Paper, *Working for Patients* (Secretary of State for Health and Others 1989) furthered this process with proposals for integrating new management systems of financial and quality controls in order to deliver a good, cost effective, service to patients (para. 1.13).
(b) However, it was not until the subsequent legislation — NHS and Community Act of 1990 — that (quasi-) market principles were *overtly* injected into this new decentralized model of the health service in the United Kingdom.

Even so, the policy was not as overtly market oriented as Margaret Thatcher, the then prime minister, had wanted. Apparently, she would have favoured the actual privatization of hospitals and clinics and the encouragement of private health insurance (Marmor and Plowden 1991: 17). Instead, what emerged was the concept of the 'internal market' which has many parallels with the U.S. concept of Health Maintenance Organizations (HMO) as outlined by Enthoven (1985) in the discussions surrounding the re-organizations (Dent 1993). In this new system, the Health Authorities are responsible for identifying the health needs of the community and *purchasing* (i.e. acting as a consumer) from hospitals and clinics (etc.) who are the *providers* (producers) of the services. The General Practitioners are also intended to become *purchasers* (consumers), on behalf of their patients, within this 'marketplace'. This new system is based on a separation of functions between the *purchaser* and *provider* of health services. The purchaser is the health authority who, on behalf of the citizenry (or fundholding General Practitioner on behalf of her/his patients) has the duty to obtain the 'best' price/quality health service. It does this through 'contracting out' the service to different hospitals which are (formally at least) in competition with each other. Hospitals are also able now to become 'self-governing' trusts operating, in principle, as independent commercial enterprises within the internal market.

Accounting for Treatment

In order to meet the requirements of the internal market, and particularly the new contract arrangements, all hospitals are now required to install comprehensive resource management and quality assurance systems

(Packwood et al. 1991; Dent 1993; Keen 1994). Resource Management (RM), has been defined by the NHS Resource Management Directorate (Bullas 1989) as,

> '[A] hospital management process involving doctors, nurses and other clinical and managerial staff in strategic and operational decision making . . . a process underpinned by a patient based information system . . . .' (para. 1.2)

The supporting information system, known as the 'Case-Mix Management' system (Packwood et al. 1991: para. 1.1), is intended to provide a means of costing the treatment and hospital care of each patient, and is based closely on the DRG (Diagnostic Related Groups) system used in United States (Sharples 1987: 27–31). It is designed to provide

> '[a common] information data-base to clinicians and managers as to aid to improve effective and efficient use of resources and measurable improvement in patient care.' (DHSS 1986: para. 2.1)

Under RM arrangements, hospital consultants are directly responsible for their clinic budgets. This touches on a central sensitivity over the issues of medical autonomy and accountability (Dent 1994). As already mentioned, it is the government's clear policy intention that the medical profession will become more closely incorporated within the NHS and to this end it has adopted a package of reforms that combines the principles of 'loose coupling' with a budgetary system (Covaleski and Dirsmith 1983).

The success of the new arrangements, however, remains unproven and the limited evidence that does exist is far from promising. The RM project was implemented experimentally at six hospitals (Packwood et al. 1991), and the results can only be described as mixed.

> '[T]he [hospitals] . . . found that . . . implementing systems . . . took much longer than originally imagined . . . the [hospitals] had to learn as they went. [Hospitals] also reported that they lacked sufficient NHS staff to cope with such a large-scale implementation. Taken together, this meant that often the flow of data . . . got worse before it got better . . . .' (Packwood et al. 1991: 44)

The coding and patient classification systems that lay at the heart of the 'Case Mix' system were not used routinely at any of the hospitals (with the partial exception of one). '[I]nvolvement was patchy, and most work in this area remained experimental' (Packwood et al. 1991: 50), whilst the state of the nursing systems was even worse, reflecting 'patchy developments at all sites . . . [and] little to show for a great deal of effort' (Packwood et al. 1991: 53). If the new RM and purchaser–provider arrangements are to work, it is clear that they cannot be too reliant on the IT systems available to provide a 'technological fix', at least, not in the short term.

The programme of changes in the NHS has been ongoing for some time (certainly since the introduction of 'general management' following the Griffith's Inquiry in 1983). The transformation has been from an hierarchical, centrally funded, administrative system with a division of labour dominated by the medical profession to a *formally* decentralized system of autonomous units (i.e. hospitals, general practice and community clinics, etc.) in market competition or a contractual relation, one with the others. These new arrangements are intended to be managed by inter-disciplinary teams of business managers and health-care professionals headed by senior doctors in the role of clinical directors. The newly organized hospitals are intended to reflect the new patient-centred culture whereby the focus of the services and the financial management is directly linked to the individual patient and her/his care. The system is to be co-ordinated and integrated via a complex IT-based system. While the success or failure of the new arrangements is of central interest, it is not the immediate concern here. Rather, the aim is to examine the changes, to see whether or not they correspond to some notion of postmodernity and whether such a notion is meaningful.

Changes in the National Health Service: A Postmodernist Interpretation

This section will deal with the *prima facie* evidence that the organizational changes in the NHS over the last decade or so reflect a general move towards a post-bureaucratic organization form which might be interpreted as postmodern. The government has overseen the introduction of the following measures:

- The commodification of health service provision with the introduction of detailed cost and quality controls (Tuckman and Blackburn 1991; Starkey 1992; Lash and Urry 1994: 207–210).
- Transforming the relation between patient and hospital/clinic from 'supplicant' to 'consumer' and thereby changing health-care provision from being a citizens' right to a customer service (Johnson 1972; Strong 1979).
- Comprehensive IT systems to underpin and facilitate the organizational changes.

To achieve these objectives, the state administration has pursued a strategy of actively transmuting the NHS culture (Ranade 1994: 82–99) from one dominated by professionalism and 'rational paternalism' (Klein 1989) to one imbued with the rhetoric of the market.

The NHS currently comprises a great many hospitals and clinics, more and more of which are becoming organizationally autonomous contractors to the health authorities. The health workers, including the professions, are being re-organized into polyvalent groupings (or the work has been 'contracted out') while the whole health-care system is being underpinned by increasingly sophisticated IT systems. This new and

still emergent version of the NHS has much in common with the new and postmodern organizational forms identified by Heydebrand (1989) and Clegg (1990). The new NHS system could even be said to have much in common with a system of franchising very similar to Benetton's, with the hospitals and clinics franchised by the Department of Health to 'sell' health-care services so long as they comply with detailed quality standards. Again, like Benetton's these NHS hospitals are intended to have IT systems that provide itemized details, including costs, of each patient's treatment and 'hotel-type' services (Clegg 1990: 120–125). To label an organizational arrangement as 'postmodern' because it corresponded with the dimensions on Clegg's model (1990: 203) would, however, be over-simplistic. It is equally possible to recast the franchise model as a variant of Weber's legal–rational bureaucratic organization. The alternative here is Ritzer's (1993) McDonaldization thesis. In this version the pressures to control costs and increase efficiency have given rise (in the U.S.) to new forms of bureaucratic controls in the form of a McDonaldization of health-service provision (1993: 52–55, 79–80, 139–141). There are, according to Ritzer, four basic dimensions at the heart of the McDonald's model (1993: 9) First, *efficiency*, based on Taylorist and Fordist principles of work organization. Second, a service that can be *quantified and calculated* both in terms of how the tasks are performed and in the price and quality of the product. Third, *predictability*, so that no matter in which McDonald's restaurant one eats, one always eats exactly the same food. Finally, *control* by replacing human skills and knowledge with technology, but a system of control that is not exercised through a monolithic corporate hierarchy but via a tightly controlled franchising arrangement. There is a prima facie case that the internal market within the National Health Service works in a similar way. The new 'franchised' arrangements between hospitals and health authorities and general practitioners (i.e. purchaser–provider relations) has led to a McDonaldization (Ritzer 1993) of the system. The extreme rationalization of hamburger-style franchised and standardized catering is possible, however, because it does not require the presence of on-site expertise and this is not the case with either cordon bleu restaurants or NHS hospitals. In the case of hospitals, these continue to remain dependent upon the professional expertise and autonomy of the doctors rather than standardized pricing systems and quality controls. In Ritzer's own view, '[t]he ultimate irrationality of the rationalization of medicine would be the unanticipated consequences of a decline in the quality of medical practice and a deterioration in the health of the patients' (1993: 141). For this reason he asserts that 'health professions and their patients need to learn how to control rational structures and institutions to ameliorate their irrational consequences' (1993: 141).

Whilst one can identify elements of McDonaldization within the new National Health Service in terms of the franchise-type relations between health authorities and hospitals there are also important differences.

First, as already mentioned, the central role of professional expertise limits the extent to which new technologies can replace the doctor: an important role remains for judgement and discretion in the management and treatment of ill health. Second, measurement and assessment of the quality of service is not limited to the patients' or managers' evaluations. Medical staff, unlike staff working at a McDonald's restaurant, will claim an ascendancy in judging whether their work is of a high quality or not. Third, the organization of hospitals is not determined by the quasi-franchiser in the form of the health authority. It is up to the staff and management at the individual hospitals to decide. There is, in short, more flexibility than is available to a McDonald's franchisee. Far more problematic for a postmodern interpretation is the post-Fordist organizational model.

Post-Fordism or Postmodernism?

The new organizational forms identified as postmodern by Clegg (1990) are more frequently categorized as post-Fordist (Reed 1992: 230). Very few analysts, other than Clegg (1990), Reed (1992: 226–237) and Boje and Dennehy (1993) have conflated the two models (postmodernism and post-Fordism). It may be, however, that the two, rather than being fused together, are closely intertwined. It is this possibility that is explored here.

In the case of the NHS, the new organizational arrangements are the consequence of a politically driven post-Fordism of a right-wing kind (to paraphrase Rustin 1989: 75). Despite much government rhetoric, the search was for new forms of organizational control rather than finding new and more flexible ways of providing consumer choice. Nevertheless, in searching for new solutions that met their own criteria, the Conservative administration opened up the multiplicity of power relations (dominated by the medical profession) that characterizes hospitals. It is within this space of 'unintended consequences' that we find elements of postmodernity beginning to permeate the public sector of health care in the United Kingdom.

On page 876, a distinction was made between the epistemology and periodization of postmodernism. The epistemology component pointed to a growing interest in the meanings of organizations in the wake of a realization that a rationalist basis is insufficient. The loss of faith in the doctrines of scientific management and the like have opened up management discourse to the 'agonistics' of postmodern language games and Derridean deconstruction. Such an analysis does not, however, offer a basis for claiming the introduction of the (managed) market into the NHS and has also led to the introduction of postmodernism into the organization of the NHS. Such an assertion could better rely on Lash (1990) and Lash and Urry's (1994) specific arguments relating to concepts of *de-differentiation* and *aestheticization*. Just as digitalization has fundament-

ally changed the relationship between computers, compact discs, videos and communication technologies (Lash 1990: 12) so too has the management strategy of relying more on market-orientated organizational arrangements than on bureaucratic forms. This general strategy has been underpinned with the adoption of proselytizing management cultures. To borrow a term favoured by Lash (1990) and Lash and Urry (1994), all this points to an increasing aestheticization of management.

The social nature of health and ill health has also undergone important changes. They have, to a large extent, been transformed from medically defined conditions *à la* Talcott Parsons (e.g. Gerhardt 1987) to, increasingly, consumer goods. This is something for which the U.K. government is not solely responsible, witness the popular interest in jogging, aerobics and health maintenance activities (and the related goods and services on offer in the private sector). Nevertheless, in attempting to displace the centrality of allopathic medicine by preventive methods of health promotion, the administration has placed greater weight on the consumers' interpretation of their own health needs and demands. There is, in short, a growing aestheticization of health. This, according to Lash and Urry (1994), would be a sign of postmodernism although they overlook the point in their own analysis of the NHS.

Lash and Urry (1994: 15) claim that a distinction can be made between cognitive and aesthetic goods:

> 'What is increasingly being produced [in contemporary political economies] are not material objects, but signs. These signs are primarily of two types. Either they have a primarily cognitive content and thus are post-industrial or information goods. Or they primarily have an aesthetic, *in the broadest sense of the aesthetic*, content and are primarily postmodern goods. . . .' (emphases added)

This distinction is derived from Baudrillard's notion of 'sign value' which is counter-posed to the modernist (Marxist) concept of 'exchange value' and pre-modernist 'use-value' and is a particularly abstract concept, a 'simulacrum of a simulacrum'. The aestheticization of goods takes place through the design process and 'branding' by which marketeers and advertisers attach images to goods. It also occurs through the complicity of producers and consumers in, for instance, the semiotic work carried out by tourists on their travels (Urry 1990) and, by extension, patients undergoing treatment.

The distinction between cognitive and aesthetic signs offers an interesting and possibly useful way of beginning to analyze the new organizational forms emerging within the NHS. This is not a view, however, shared by Lash and Urry (1994: 210) themselves. They argue that whilst the changes that have taken place are of a post-Fordist kind they have not led to a post-Fordist (let alone postmodern) transformation. There are three reasons, they tell us, for this being the case:

1. It is not clear who are the consumers and therefore to whom the managers need to respond most directly.

2. The information and contracting structures underpinning the quasi-market arrangements require more, not fewer, bureaucratic hierarchies.
3. The work of doctors has become more Fordist with the introduction of the new contracts and medical audit following the 1989 White Paper.

To accept these points, however, would be to misinterpret the impact of the changes.

First, there is the issue of identifying the consumers. Currently, the health authorities and fundholding general practitioners are the purchasers on behalf of the patient/consumers of the services. The health authorities, however, are obliged to monitor closely their citizenry's views and experience of the health services (e.g. Ranade 1994: 110–112). This corresponds with private sector management carrying out market surveys and the like.

Second, the alleged requirement for more, not less, bureaucracy. It is true that between 1989 and 1991 there was nearly a threefold increase of managers in the NHS (Ranade 1994: 73). This reflects a move from an administered to a managed system. The government devolved increasing responsibilities to the hospital managers with the intention of constituting them as a countervailing power to doctors (Robinson 1994: 6). The growth was also, no doubt, part of the general 'histrionics' of the new managerialism and intended to ensure eventual acceptance of the new organizational order (Cox 1991: 99). None of these points add up to a growth in bureaucracy, even if it has meant more managers.

Finally, there is the assumption that contracts and medical audit means a more Fordist work situation for doctors. As I have argued elsewhere (1993) the reality has been more of incorporation than subordination (or deprofessionalization or proletarianization). Previously, the arrangements between the National Health Service and the medical profession might best be described as one of accommodation. With the introduction of new contracts and medical audit, expectations on the part of managers and doctors have certainly substantially changed. Nevertheless, it remains the case that it is the doctors themselves who determine the criteria defining the quality of medical care.

In general terms, the argument I am pursuing here is that the NHS has taken on a predominantly post-Fordist organizational form as a direct consequence of government policy. In the process, however, the health service has undergone further changes broadly corresponding with Lash (1990) and Lash and Urry's (1994) notions of 'de-differentiation' and 'aestheticization' in the organization and delivery of health-care services. It is these that are the postmodern elements within the new organizational arrangements.

In order to avoid any over-generalizations I will now turn to a case study of a specific general hospital. The hospital was not selected for its representativeness but rather because of its peculiarity. The intention here is to present a working example of an emerging organizational

form that is singularly highly flexible. It will be clear that this hospital's organization is not a variant of McDonaldization (Ritzer 1993) or any other form of Fordism (Lash and Urry 1994: 210). Rather there is a close intertwining between the rationality of post-Fordism, the de-differentiated organizational arrangements and the aesthetics of a proselytizing management culture.

The New Hospital Case Study: A Soft Organizational Approach

Research Methods

The hospital is a new, compact, general hospital, relatively small in size and employing only 35 full-time consultants, the vast majority of whom have only been recently appointed. It is less than ten years old, recently officially opened by the member of the British royal family whose name has been adopted for the hospital. The name has been changed here to the 'New Hospital' in order to ensure the anonymity of those interviewed. The hospital is located in an ever growing 'new town' which is the industrial centre of an otherwise rural part of the country.

The case study was carried out over the period 1991 to 1993, with most interviews being carried out over the period September to April, 1992–1993. Data was collected from semi-structured taped interviews with informants drawn from management, doctors and nurses (i.e. directly involved in the management processes).

An NHS Hospital and the Soft Organizational Form

At the New Hospital, the General Manager implemented his chosen interpretation of the edicts of the Resource Management and the NHS and Community Care Act in a peculiarly participative way. It was a policy concerning the organizational culture of the hospital, one decided on by himself but implemented participatively. This aestheticization process can be viewed as an organizational equivalent of *populist ventriloquism* given that the general manager was introducing his preferred system in the name of participation and involvement (Hall 1978 cited in Jessop et al. 1988: 71–72).

The general manager defined this strategy as his 'soft organizations' approach:

> '. . . I want to do a bit of business, I want to see people . . . . I . . . mak[e] connections — . . . what you would call "soft" organizational communications [these] are extremely easy around here . . . .' (General Manager)

The concept is a kind of organizational equivalent to postmodern architects, such a Krier, who have argued in terms of rejecting sky-scrapers and tower blocks in favour of more small local communities 'cities

within cities' [cited in Harvey 1989: 67–68]. Neither the architect nor the manager are being nostalgic for a romanticized pre-modern past, but are seeking alternatives to modernist arrangements. In the case of the hospital, it is an attempt by the general manager to carve out a niche within the National Health Service that Peters and Waterman (1982) would describe as 'skunk works':

> '[A part of an organization characterized by an] almost radical *decentralization* and *autonomy*, with its attendant *overlap*, *messiness* around the edges, *lack of co-ordination*, internal competition, and somewhat *chaotic* conditions, in order to breed the entrepreneurial spirit.' (cited in Ritzer 1993: 180, Ritzer's emphases)

Within this niche, the general manager's own strategy seemed to share some commonality with the proponents of Soft Systems Methodology (SSM) (Checkland 1981; Checkland and Scholes 1991). Moreover, the proponents of SSM even suggest (apparently without irony) that their approach may be postmodern:

> '[SSM can be] used not so much to plan calculative action . . . but rather to guide and make sense of the discourse [of re-organization]. This is, perhaps, *postmodern* . . . SSM is being used to help an observer community which constructs interpretations of the world, these *interpretations* having no universal status. New interpretations have led to new ways of structuring and managing [organizations] but not in any absolute or Utopian sense . . . .' (Checkland and Scholes 1990: 235–236, some emphases added)

Similarly, within the hospital, the general manager acted as a 'guide' and 'interpreter'. Thus, the 'soft' organizational arrangements were consciously not constructed to alienate the doctors but to incorporate them into a central role within the new organizational arrangements. Instead of adopting the officially recommended clinical directorate model, a different inter-disciplinary model was adopted. This was one based on the clinical units (e.g. General Medicine, Surgery, Paediatrics, etc.). Each was chaired by a consultant who was also, automatically, a member of the Hospital Management Board where the doctors were, numerically, more strongly represented they would have been under a clinical directorate system. However, it also meant that the board was a large, unwieldy body. The official management committees functioned, however, to formalize decisions agreed on an informal, day-to-day basis.

Each unit was headed by a consultant doctor and supported by a senior nurse. The work of these inter-disciplinary teams was co-ordinated by one of two associate general managers, both of whom were nurses. This arrangement was to ensure that the work of the different units co-ordinated overall as well as giving the nurses, as a body, power and influence within the new structure.

The centrality of the consultants to the 'soft organizational system' was further reinforced by their being accommodated in offices adjacent to

that of the general manager (and certainly nearer than those of the managers). This provided the consultants with easy access to the general manager, but it also ensured that he would have privileged access to the medics' own informal networks:

'I've moved all the consultants so that they are all on this floor here. . . . Purely, because the view is that those "lads" [*sic*] are the ones that are going to "screw you up". They have several needs. One of their needs is to be near me — and loved by me. . . . And I've got a need to see the "whites of their eyes" so I know what's worrying them. So, on the *informal* network . . . you "smell" the . . . "smoke" on the Monday morning and by doing that you can feed back through the *informal* network very quickly.' (General Manager)

At the same time, the doctors previous 'power-base' in the organizational structure, the Medical Executive Committee (pre-existing in all NHS hospitals), was replaced by the Unit Medical Advisory Committee, which, itself, has no formal powers.

Despite the organizational arrangements being the 'brain-child' of the general manager, the consultants were not naively seduced by the model. As one of them explained:

'[O]ur view . . . was [that] . . . either we were going to be managed by managers (who in many cases have no idea what they're doing) or we would . . . manage ourselves.' (Consultant Surgeon)

Whilst keen to manage themselves at the unit level, however, they did not see the clinical directorate model as particularly appealing because it would take them away from their medical work. This interpretation is supported by an interview with a clinical director at a nearby hospital. It emerged from the interview that these doctors were a fairly passive group, who the general manager had needed to cajole into taking on their new role.

'My colleagues decided that I would be the best person for the job [as clinical director] which probably means they didn't want it . . . . I am by far the youngest . . . .' (Eye Consultant)

The general policy of this other hospital was to implement the new organizational arrangements contained in the NHS and Community Care Act of 1990 as if they were bureaucratic edicts. By contrast, the 'soft' organizational approach introduced within the New Hospital' was far more flexible and informal. It was also effective at actively involving the doctors in the management of the hospital. An example of the effectiveness of the approach was the general manager's strategy relating to 'Trust' status (i.e. for the hospital to become completely autonomous within the National Health Service). As one of the consultants explained:

'[When] the hospital opened . . . I think there [w]as a general, almost unanimous, viewpoint among the consultants that they didn't want anything to do with [Trust status]. . . . Over the next year [however] . . . it really gathered momentum. . . . I'm not sure we ever made any conscious decision. . . . It just came clear that the majority of people wanted to go that way.' (Consultant Surgeon)

This is another example of *populist ventriloquism* (Hall 1978 cited in Jessop et al. 1988: 71–72). The consultants did not see 'Trust' status, as having any direct impact on their work situation. Although they accepted the reality of budgetary constraints, as do U.K. doctors generally, according to Harrison and Schulz, they now regard 'overall financial limitations as being legitimate restrictions on their autonomy . . .' (1989: 203). They would be hostile to any external controls on their clinical practice:

'We don't anticipate [Trust status] changing our work patterns one iota because if it does there will be a "holy hell" to pay and the . . . General Manager knows that.' (Consultant Paediatrician)

Nevertheless, within the three years of opening, the medical staff had accepted shared responsibility for managing the delivery of the clinical services within budgetary constraints.

Computer Systems, Quality Assurance and Organizational Control

Whilst the management at the New Hospital adopted a flexible organizational response to the new internal market it cannot be said that there was adequate IT to support of the kind assumed by proponents of post-Fordist, post-modern or post-bureaucratic organizations (Heydebrand 1989; Clegg 1990). This was largely related to the limitations on the resources and services provided by the health authority.

The hospital was provided with an extensive set of IT systems covering the core patient-related activities, staffing and finances as well as more specialist laboratory systems and the like. These systems, however, were inadequate for the demands of resource management. This was a matter of some concern, but not one unique to this hospital (Dent 1991; Coombes and Cooper 1992) and is compatible with the findings from the National Health Service resource management experimental sites cited earlier (Packwood et al. 1991: 44). The reasons for the problems lay with both the people and the systems.

In terms of people, within technology management generally there is an acceptance of a need for 'hybrid' management i.e. a manager who knows enough about the organization's activities and IT systems to understand how best the latter can aid the former (Earl 1989; Rose 1991: 95–105). At the hospital level it was the resource management project team who functioned in the 'hybrid domain'. Yet, in the case

of the New Hospital neither the project manager nor any of the team were particularly knowledgeable in the area of IT having followed careers in NHS administration or nursing until their current appointment. In an attempt to overcome this problem, the project manager was assisted by the computing specialists employed by the health authority. In any case, the computer systems already in place were provided by the health authority. It was generally accepted, however, that the service provided was inadequate as it was based on rather antiquated ICL systems. Nevertheless, the New Hospital took a pragmatic view, seeing the health authority's service as the most cost effective service they were likely to get. As the general manager at the New Hospital explained:

'Instinctively I would have them *decentralized* but practically I think we've got to be *centralized* because of the "economies of scale" . . .' (emphases added)

The view of the health authority directorate was that they too still had a role to play in the area of hospital computing services.

'[Taking] the view . . . resource management . . . was about [hospital] "ownership" *but* with the central steer and policy direction mainly on issues of IT.' (Director of Purchasing and Q.A.)

In practice, the authority and the hospital had inherited expensive systems and the vested interests of the authority's computer specialists, both of which seriously hindered the development of flexible IT systems appropriate for the hospital's requirements. In practice, the authority's 'central steer; was in the area of 'quality assurance' and 'medical audit' rather than IT systems. The quality issues were mandatory elements within the new purchaser–provider arrangements, whereas IT was not.

To start with, quality measures within the purchaser contracts, as intended for impinging on the doctors, were very general:

'You will not have people sitting in Outpatients for three hours. You . . . will tell GPs that someone has been discharged within 24 hours. . . . [T]hese are the very practical things we are saying to . . . [the hospitals] . . . and that's been helpful because its actually structured the debate — made quality much more tangible.' (Director of Purchasing and Q.A.)

In the longer term, the purchasing health authority will be interested in the results of medical audit 'in a management sense' and these will be:

'. . . picked up through the contracting process . . . in [asking] "OK, what's your re-admission rate like, what's your operation failures like?" Those sorts of things we will be writing into contracts. But its very early days.' (Director of Purchasing and Q.A.)

This remains the case today. Medical audit and quality assurance was one area in which the hospital did have their own IT support.

To summarize, the New Hospital organizational form was not dependent upon the IT systems available. If anything, the technology hampered the emergence of the new organizational arrangements. These combined the post-Fordist strategy of incorporating medical staff within the hospital's management structure with a post-modern de-differentiation and aestheticization within the organizational culture.

NHS Hospitals and Postmodernity: Some Conclusions

A postmodern contribution to the organizational analysis of the National Health Service enables one to extend beyond the limitations of the productionist focus of post-Fordism and the modernist interpretations of Lash and Urry (1994). However, unless we take into account the newly negotiated cultures and aesthetics of the organization's component parts: hospitals and clinics, etc., our understanding of the impact of these changes will be very limited. It is the intertwining between the post-Fordist flexibilities and postmodern cultural aestheticization that gives rise to the range of de-differentiated organizational forms within the service. These reflect the local circumstances, resources and possibilities both within the community and the organization. While hospitals do provide services to patients from other parts of the country, most of their patients will be citizens living in the local communities. Moreover, the loose-coupling and budgetary constraints of the new system has not given rise to any significant 'McDonaldization' of the National Health Service as the commodification of ill health has begun to take hold. This is largely because the role of professionalism and medical dominance, whilst changed in some important respects, remains. Instead of a process of de-professionalization, doctors have suffered nothing worse than a comfortable incorporation within the new system as senior managers.

The inclusion of the case study was an attempt to explicate the way in which the aestheticization of management and the de-differentiation of the organization may be realized locally. Further, the intention was to elucidate as why local management practices and organizational arrangements are not to be understood as epiphenomena or residual categories but rather as essential components to any analysis. Thus, the 'soft organization' model was the metaphor that made sense of the organizational arrangements and management strategies within the hospital. The underlying imagery parallelled that claimed for Checkland's soft systems methodology in that it was a localized interpretation of how the hospital's organization was to be constructed and managed. It enabled the general manager to orchestrate a flexible, informally networked and autonomous, organization. This was a serious game in

which the organizational players recognize very clearly the inherent instability of the 'internal market' and the implications this could have for their relations with other players within the National Health Service.

In this context, the 'soft organizational' form was neither wholly pragmatic nor simply a deceptive gloss for a McDonald's-type standardized franchise. First, the signification of the organizational form was one that has been assigned to it through a process of aestheticization rather than simply technical rationality (i.e. it was the legitimation of the informal networks over the formal management structures that characterized this organizational form). Second, the health authorities were unable to impose any contractual requirements that would parallel the McDonald's franchising arrangements. Moreover, the New Hospital management (including senior medical and nursing personnel) were not seeking to respond to the imperatives of the internal market in a way commensurable with the McDonald's highly rationalized form. Instead, they were intent on adapting and developing their own autonomy and flexibility in a manner more in line with Heydebrand's (1989: 327) post bureaucratic or Clegg's (1990: especially 181) postmodern organizational forms. It was an organization in which the culture was used politically to integrate all otherwise loosely coupled, centrifugal system of complex and fragmentary relational forms — to hybridize the words of Heydebrand (1989) and Clegg (1990). Lyotard's assertion that the postmodern discourse is driven by 'agonistics' may be relevant in terms of theorization/epistemology but the consequences of the new organizational forms are more real than just a competitive interest in discourse. It is associated with a process Lash and Urry (1987) have referred to as the disorganization of capital and represents a new order akin to 'high Technology feudalism'. It is an organizational world in which 'legal rationality' has only localized significance. As Smart (1992: 180) explains:

> 'The opposition to "reason" frequently attributed to "postmodern" analyses is, to be more precise . . . an opposition to a totalizing idea of reason. . . . There is no "postmodern" opposition to rationality *per se*. Rather it is the existence of a plurality of "rationalities". . . .'

In these terms it is perfectly possible that the postmodern, post-bureaucratic, organization may imply a dystopic and disorganized future within late capitalism (e.g. Lash and Urry 1994: 12). An interpretation that may well apply to the example of the National Health Service.

Note

* An earlier version of this paper was presented at the 11th EGOS Colloquium, Paris, July, 1993. I wish to express my thanks to Working Group 3A (including those of my discussant) for both their supportive and critical comments. I would also like to thank the *O.S.* and reviewers who have also been very helpful.

References

Abel-Smith, B.
1984 *Cost containment in health care: a study of 12 European countries, 1977–83*. London: Bedford Square Press/NCVO.

Albrow, Martin
1970 *Bureaucracy*. London: Macmillan.

Baudrillard, Jean
1983 *Simulations*. New York: Semitext(e).

Bauman, Zygmunt
1992 *Intimations of postmodernity*. London: Routledge.

Boje, David M., and Robert F. Dennehy
1993 *Managing in the postmodern world*. Dubuque, Iowa: Kendall/Hunt.

Bourdieu, Pierre
1984 *Distinction: A social critique of the judgement of taste*. London: Routledge and Kegan Paul.

Bullas, Sheila
1989 *Case mix management system: core specification*. Resource Management, Department of Health: London.

Burns, Tom, and G. M. Stalker
1961 *The management of innovation*. London: Tavistock.

Burrell, Gibson, and Gareth Morgan
1979 *Sociological paradigms and organizational analysis*. London: Heinemann.

Checkland, Peter B.
1981 *Systems thinking, systems practice*. Chichester: Wiley.

Checkland, Peter B., and Jim Scholes
1991 *Soft systems methodology in action*. Chichester: Wiley.

Clegg, Stewart R.
1990 *Modern organizations: organization studies in the postmodern world*. London: Sage.

Coombes, Rod, and David Cooper
1992 'Accounting for patients? in *Continuity and crisis in the NHS*. R. Loveridge and K. Starkey (eds.), 118–125. Buckingham: Open University Press.

Cooper, Robert
1989 'Modernism, postmodernism and organizational analysis. 3: the contribution of Jacques Derrida'. *Organization Studies* 10/4: 479–482.

Cooper, Robert, and Gareth Burrell
1988 'Modernism, postmodernism and organizational analysis: an introduction'. *Organization Studies* 9/1: 91–112.

Covaleski, Mark A., and Mark W. Dirsmith
1983 'Budgeting as a means for control and loose-coupling'. *Accounting, Organizations and Society* 8/4: 323–340.

Cox, David
1991 'Health service management' in *The sociology of the health service*. J. Gabe, M. Calnan, and M. Bury (eds.), 89–114. London: Routledge.

Dent, Mike
1991 'Information technology and managerial strategies in the NHS: computer strategies, organizational change and the labour process'. *Critical Perspectives on Accounting* 2: 331–360.

Dent, Mike
1993 'Professionalism, educated labour and the state: hospital medicine and the new managerialism'. *The Sociological Review* 41/2: 244–273.

Dent, Mike
1994 'Doctors, peer review and quality assurance' in *Health professions in Europe*. T. Johnson, G. Larkin, and M. Saks (eds.), 86–102. London: Routledge.

Department of Health and Social Security
1986 *Health services management: resource management (management budgeting) in health authorities*. Circular HN (86) 34.

Derrida, Jacques
1978 *Writing and difference*. London: Routledge and Kegan Paul.

Derrida, Jacques
1981 *Positions*. Chicago, IL.: University Press.

Döhler, Marian
1989 'Physicians' professional autonomy in the welfare state: endangered or preserved?' in *Controlling medical professionals: the comparative politics of health governance*. G. Freddi and J. W. Björkman (eds.), 178–197. London: Sage.

Earl, Michael J.
1989 *Management strategies for information technology*. Hemel Hempstead: Prentice Hall.

Eldridge, John E. T.
1973 *The sociology of industrial life*. London: Nelson.

Elston, Mary Ann
1991 'The politics of professional power: medicine in a changing health service' in *The sociology of the health service*. J. Gabe, M. Calnan and M. Bury (eds.), 58–88. London: Routledge.

Enthoven, Alain C.
1985 *Reflections on the management of the National Health Service*. London: Nuffield Provincial Hospital Trust.

Featherstone, Mike
1991 *Consumer culture and postmodernism*. London: Sage.

Foot, Michael
1973 *Aneurin Bevan*, Vol. 2. London: David-Poynter.

Fox, Alan
1974 *Beyond contract: work power and trust relations*. London: Faber and Faber.

Foucault, Michel
1977 *Discipline and punish*. Harmondsworth: Penguin.

Freddi, Georgio and James W. Björkman (eds.)
1989 *Controlling medical professions: the comparative politics of health governance*. London: Sage.

Freidson, Eliot
1970 *Medical dominance*. New York: Atherton Press.

Gerhardt, Uta
1987 'Parsons, role theory, and health interaction' in *Sociological theory and medical sociology*. G. Scambler (ed.), 111–133. London: Tavistock.

Giddens, Anthony
1987 *Social theory and modern sociology*. Cambridge: Polity.

Giddens, Anthony
1990 *The consequences of modernity*. Cambridge: Polity.

Griffith's Inquiry
1983 *NHS management inquiry*.

Hall, Stuart
1978 *Policing the crisis*. London: Macmillan.

Ham, Christopher
1985 *Health policy in Britain*, 2nd Ed. London: Macmillan.

Harrison, Stephen, and Rockwell I. Schulz
1989 'Clinical autonomy in the U.K. and the U.S.A.: contrasts and convergence' in *Controlling medical professions: The comparative politics of health governance*. G. Freddi and J. W. Björkman (eds.), 198–209. London: Sage.

Harvey, David
1989 *The condition of postmodernity*. Oxford: Basil Blackwell.

Hassard, John
1993 'Postmodernism and organizational analysis: an overview' in *Postmodernism and organizations*. J. Hassard and M. Parker (eds.), 1–24. London: Sage.

Hassard, John, and Martin Parker, *editors*
1993 *Postmodernism and organizations*. London: Sage.

Heydebrand, W. V.
1989 'New Organizational Forms'. *Work and Occupations* 16/3: 323–357.

Jessop, Bob, Kevin Bonnett, Simon Bromley, and Tom Ling
1988 *Thatcherism*. Cambridge: Polity.

Johnson, Terence
1972 *Professions and power*. London: Macmillan.

Johnson, Terry, Gerry Larkin, and Mike Saks, *editors*
1994 *Health professions in Europe*. London: Routledge.

Keen, Justin
1994 'Information policy in the National Health Service' in *Information management in health services*. J. Keen (ed.), 16–28. Buckingham: Open University Press.

Klein, Rudolf
1989 *The politics of the National Health Service*, 2nd Ed. London: Longman.

Lash, Scott
1990 *The sociology of postmodernism*. London: Routledge.

Lash, Scott, and John Urry
1987 *The end of organized capitalism*. Cambridge: Polity.

Lash, Scott, and John Urry
1994 *Economies of signs and space*. London: Sage.

Lyons, David
1988 *The information society: issues and illusions*. Cambridge: Polity.

Marmor, Theodore R., and William Plowden
1991 'Spreading the sickness'. *Times Higher Educational Supplement* 17, 25th October.

Packwood, Tim, Justin Keen, and Martin Buxton
1991 *Hospitals in transition: the resource management initiative*. Milton Keynes: Open University Press.

Parker, Martin
1992 'Post-modern organizations or postmodern organization theory?' *Organization Studies* 13/1: 1–17.

Peters, Tom, and Robert Waterman
1982 *In search of excellence*. New York: Harper and Row.

Piore, Michael J., and Charles F. Sabel
1984 *The second industrial divide*. New York, Basic Books.

Rabinow, Paul, *editor*
1984 *The Foucault Reader*. London: Penguin.

Ranade, Wendy
1994 *A future for the NHS? Health care in the 1990s*. London: Longman.

Reed, Michael I.
1992 *The sociology of organizations: themes, perspectives and prospects*. London: Harvester-Wheatsheaf.

Ritzer, George
1993 *The McDonaldization of society*. Thousands Oaks, CA: Pine Forge Press.

Robinson, Ray
1994 'Hospitals in the market' in *Information management in health services*. J. Keen (ed.), 3–15. Buckingham: Open University Press.

Rose, Howard
1991 'The emergent IT-based enterprise?' in *New technology and manufacturing: the UK experience*. M. Dent and M. Parker (eds.), 95–105. Stoke on Trent: Technology and Organisations Research Unit, Staffordshire University.

Rustin, Mike
1989 'The politics of post-Fordism or trouble with the "New Times" '. *New Left Review* 21 (July): 55–77.

Scrivens, Ellie
1988 'The management of clinicians in the National Health Service'. *Social Policy and Administration* 22/1: 22–34.

Secretary of State for Health and Others
1989 *Working for patients*. London: Her Majesty's Stationery Office.

Sharples, Sue
1987 'DRGs and computing'. *British Journal of Health Care Computing* 4/5: 27–31.

Smart, Barry
1992 *Modern conditions, postmodern controversies*. London: Routledge.

Starkey, Ken
1992 'Time and the consultant: issues of contract and control' in *Continuity and crisis in the NHS*. R. Loveridge and K. Starkey (eds.), 54–64. Buckingham: Open University Press.

Strong, Phil
1979 *The ceremonial order of the clinic*. London: Routledge and Kegan Paul.

The Milbank Quarterly
1988 *The changing character of the medical profession*. Vol. 66, Supplement 2.

Tuckman, Alan, and Don Blackburn
1991 'Fitness for purpose: total quality management in the health service'. Paper presented at the Annual Conference of the British Sociological Association, Manchester.

Urry, John
1990 *The tourist gaze*. London: Sage.