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ABSTRACT

This article outlines a narratological approach to understanding how middle managers and senior managers in a UK National Health Service (NHS) hospital made sense of the introduction of a series of interventions, led by senior managers. The research contribution this article makes is fourfold. First, it illustrates the role of individual and group narratives in processes of collective sensemaking. Second, it discusses the importance of work narratives in the efforts of individuals and groups to define their shared identities. Third, it outlines a view of organizations as storytelling milieux in which group narratives play important hegemonic and legitimatory roles. Finally, our focus on narratives, and the plurivocal understandings of actions and events they often encompass, is, we maintain, one useful means by which polysemy can be read back into case study research.

KEYWORDS

identity ▪ legitimacy ▪ middle managers ▪ narrative ▪ NHS ▪ sensemaking

This article provides an account of how individuals and groups make sense of events in their working lives, and define their work identities, through the authoring of narratives. It focuses specifically on how senior and middle managers in one UK National Health Service (NHS) hospital defined, operationalized, and evaluated a series of executive-led interventions. The research draws on the wealth of literature which suggests that narrative is an

appropriate interpretive lens for understanding organizations and processes of organizing relating to, for example, micropolitical activity (Mumby, 1987) and change (Skoldberg, 1994). Our case illustrates the value of narrative analyses in efforts to capture 'the diversity and complexity' of processes of organization in ways which highlight 'the discursive social nature' of organizations (Barry & Elmes, 1997: 430). In particular, we argue that narratives are significant vehicles for the expression of political activity and one means by which ideas and practices are legitimated, especially during periods of change.

The narratological perspective adopted here suggests that organizations are socially constructed phenomena (Berger & Luckmann, 1966), sustained by means of social, symbolic and political processes. In a sense, organizations literally are the narratives that people author in networks of conversations, the intertextuality of which sustains an accumulation of continuous and (sufficiently) consistent story lines that in turn maintain and objectify 'reality' (Ford, 1999). While some of these narratives are fully elaborated, with plots, characters, actions and events, most are better characterized as 'fragments of stories, bits and pieces told here and there, to varying audiences' (Boje, 2001: 5). Within organizations, there are centripetal forces that seek to centralize the production of meaning, and establish unitary versions of what is and what should be, excluding other possible realities. Working against these are centrifugal forces that Rhodes (2001: 231), borrowing from Bakhtin (1986), refers to as heteroglossia, which 'invoke . . . a multi-vocal discourse that opposes the centralising imposition of the monological word'. The storytelling organization is, then, one in which the dialogical exchange of narratives, and fragments of narrative, result in a Tamara-like (Boje, 1995) polyphony of simultaneously and sequentially occurring vocalities.

A narratological approach is particularly valuable for the light it sheds on aspects of individual and group sensemaking; sensemaking being understood to refer to those processes of interpretation and meaning production whereby people reflect on and interpret phenomena and produce intersubjective accounts (Leiter, 1980). One way in which we collectively make sense of (or enact) our social world is through jointly negotiated narratives. In seeking to represent complex patterns of human interaction there is a tendency for people to construct their experiences in narrative form (Bruner, 1991: 4). Groups comprise individuals, and individuals as members of groups come to construct and share common meanings. Shared narratives constitute collective frames for understanding that integrate a group's knowledge structures, place events in causal order, serve as mnemonics, permit inferential reasoning, and transmit and reinforce third-order controls (Weick, 1995:

129). In short, individuals and groups author sensemaking/constructing narratives which permit people to organize their experiences, or 'map their reality' (Wilkins & Thompson, 1991: 20), in ways that facilitate prediction, comprehension and control in organizations.

Relatedly, there is considerable support for the view that people author 'life stories' that are identity constitutive. For McAdams (1996: 301) 'lives may be viewed as narrated texts', while in Ricoeur's (1991: 77) terms 'the narrative constructs the durable character of an individual, which one can call his or her narrative identity'. While most attention has been focused on the identity-constitutive narratives of individuals, Rappaport's (1993: 246) argument that 'an important characteristic of a community is that it has a narrative about itself' suggests that the defining characteristic of a group may be that it has its own collective identity-narrative. These narratives, both individual and shared, are, we maintain, an evolving product of conversations within ourselves and with others. Ours, thus, is a view of identity in which our internal soliloquies of self are intimately linked to the stories of others who have lived, live now, and will live in the future (Bruner, 1991: 19–20). Such a perspective suggests that narrative is a highly pervasive cognitive and cultural form that plays a fundamental role in human relations (Gabriel, 1999).

Sensemaking and identity narratives are authored within organizations that can be regarded as fractured and hierarchical locales, in which individuals and groups are implicated in reciprocal but often asymmetric power relationships (Clegg, 1981). This is an important point because it suggests that rather than 'sense' and 'identities' always being consensually negotiated, they are arguably more plausibly depicted as contested and, to an extent, imposed. Theorists interested in sensemaking have pointed out that although people prefer to assume that they share common understandings, as a matter of fact there are often fundamental inconsistencies between the perceptions of individuals and groups (Leiter, 1980: 78). Rose (1989: 1) is one of many authors who have argued that identity, individual and collective, is not just a private matter but rather 'intensely governed' by social conventions, community scrutiny, legal norms, familial obligations and religious injunctions. Subjectively construed identity (indeed all 'reality') is a power effect – a complex outcome of processes of subjugation and resistance that are contingent and perpetually shifting. Language in all its forms, and narratives in particular, are simultaneously the grounds, the objects, and the means by which struggles for power are engaged in (Westwood & Linstead, 2001).

The political role of organizational narratives as means by which asymmetric power relationships are initiated and maintained, and as boundary markers between various groups, is well established. So too is the deliberate hegemonic use of narratives differentially to highlight, marginalize, privilege

and legitimate certain interests at the expense of others (Humphreys & Brown, 2002). The concept of hegemony, originally employed by Gramsci (1971) to refer to a form of subtly masked and taken-for-granted ideological domination, is particularly pertinent to our research into how groups mobilize and reproduce the active consent of others in organizations (Laclau & Mouffe, 1985). Legitimacy, too, is a key concept for us. The attribution of legitimacy to someone, a group or something has variously been described as implying a normative acceptance of its rightness, a recognition that it is reasonable and just, and a perception that it is desirable, proper or appropriate (Suchman, 1995). Our suggestion is that individuals and groups require legitimacy as a political resource that reinforces privileged power relations and secures the acquiescence and enthusiasm of others. As we illustrate, the implementation of a series of change initiatives provides a wealth of opportunities for those closely associated with them to author narratives that maintain the active consent of dominated groups and reinforce their claim as legitimately powerful members of an organization.

To summarize, this article seeks to elaborate and exemplify a narratological perspective that conceives of organizations as polyphonic, socially constructed verbal systems characterized by multiple, simultaneous and sequential narratives that variously interweave, harmonize and clash. Individuals and groups make sense of actions and events through the authorship and mutual negotiation of narrative accounts. Subjectively, individual and collective identities are understood as constituted by the life stories that people author in their efforts to read meaning into their lives, and these self-narratives are influenced and constrained by the dominating impact of discursive practices. In specific terms, this article offers a case study of two groups' narratives in an attempt to illustrate how those involved sought retrospectively to make sense of events in ways that bolstered the legitimacy of their actions and served their interests.

Research design

This article presents the results of a qualitative research project conducted in Omega Hospital (a pseudonym) between 1995 and 1998. The most valuable source of data from which the case has been constructed was 57 semi-structured interviews of approximately 60 minutes duration, which were recorded on audio-tapes before being transcribed by the researchers and subjected to analysis. Forty-five middle managers (mostly senior nurses and ward managers), eight members of the senior management team, two medical consultants and two external management consultants, were interviewed.

While formal data collection ended in 1998, informal conversations with two senior managers, including the chief executive, and three middle managers, regarding Omega, continued until 2000. These data were captured in extensive hand-written notes made at the time, which enabled the researchers to map developments and to develop a richer ongoing understanding of processes of organizing at the hospital.

The interview data were supplemented by observations made when shadowing middle managers at work over four full days (while attending a variety of business planning, directorate and ward meetings), 24 one-day management development workshops, and two one-day marketing workshops. These observational data were captured in hand-written notes made at the time in the field. Whenever possible, statements relevant to the primary research questions made by senior managers, middle managers or external management consultants, were noted in full. Observations were analysed by the researchers in conjunction with the interview transcripts, and helped to guide the unfolding research project. Further valuable data were derived from a wealth of documentation – in the form of, for example, memos, minutes of meetings, business plans and letters – that were made available to the researchers by the respondents. Overall, the research design was longitudinal (over three years), contextual and processual.

Perhaps most importantly, we explicitly recognize that this article is an example of what Fuller and Lee (1997) refer to as 'textual collusion', in which we, as authors, and you, the reader, are deeply implicated in relations of power. In this article we represent our data in the form of two chronological and intertwined group narratives that we attribute to senior managers and middle managers. These have been pieced together by us, the researchers, in order to illustrate how those involved in two related major change initiatives, sought retrospectively to make sense of the events they experienced in ways that legitimated their actions and interests. The decision to adopt this mode of representation, and thus 'to draw attention to the inherent story-like character of fieldwork accounts' (Van Maanen, 1988: 8), reflects our concern to ensure that the different meanings attached by research participants to their experiences were adequately incorporated into the case. This said, it should be observed that the narratives we have developed are rhetorical constructs, and part of a broader authorial strategy designed to have a particular effect on our readership (Denzin, 1994).

Case context: The UK National Health Service

Towards the end of the 1980s, the Conservative government led by Margaret Thatcher implemented a series of reorganizations of the NHS in what it

labelled as an effort to make it more competitive and cost effective (Pettigrew et al., 1992). Central to this programme of reform was the break-up of what was then one giant organization into myriad separate purchasers and providers of health care, the introduction of a quasi market-based system for internal resource allocation, and the creation of a business management ethos, all framed by performance indicators set out by government. In this new policy context, hospitals such as Omega were able to opt out of control by local administrative bodies and become independent self-governing 'trusts', accountable directly to government ministers. Omega Hospital had become a trust in 1992, and had subsequently structured its approximately 3000 staff into five clinical directorates led by an executive board. During the research process, in 1997, a Labour government was elected, but did not immediately change the previous government's NHS policy.

In the rhetoric of the Thatcher government the transformation of the NHS was depicted as a movement from a 'failed' bureaucratic model to a system of entrepreneurial governance that would help it to survive. This new paradigm for the public sector championed

> enterprising qualities on the part of individuals and collectivities, characteristics such as responsiveness to users' desires and needs, keener personal ownership of one's work and the wider goals and objectives it contributes to and the ability to accept greater responsibility for securing certain outcomes efficiently.
>
> (du Gay, 2000: 6)

One key to achieving the cultural, structural and technological changes that entrepreneurial governance implied was the import of executives and managers from the private sector, and the re-training of existing NHS administrators, nursing and clinical staff in what the government considered to be best private sector practice. While the principle of sectoral transference has received some qualified support from scholars (Pettigrew et al., 1992), most have argued that it is inappropriate to employ private sector practices in a public sector context without taking into account the distinctive characteristics of public sector organizations (Ackroyd et al., 1989). These debates have extended into hospitals across the UK, where internal contests regarding the appropriateness and applicability of private sector practices have complicated the environment in which individuals and groups pursue their career projects, while also seeking to present themselves and their policies as legitimate.

Programmatic sectoral transference of this kind has had a tremendous impact on NHS middle managers. This new environment, at first, seemed to benefit middle managers. Their numbers increased (Ranade, 1997: 106), and

an explicit government agenda that 'management must manage' (DHSS, 1983), meant that they were 'informed, motivated and empowered' (NHSTD, 1992: 20) within a decentralized decision-making framework. Arguably, this allowed middle managers to wield considerable power through the role they played in linking small groups of senior managers with key constituencies such as clinicians, laboratory scientists and other professional groups, as well as exerting influence over both strategy formation and implementation (Wooldridge & Floyd, 1990). However, more recently, a trend towards de-layering has created considerable disillusionment and disaffection among middle managers in the NHS (Hancock, 1994).

Narrative constructions and the new policy initiatives at Omega hospital

This section provides an account of the group narratives of senior and middle managers as they relate to two sets of change initiatives. The narratives were not related to us in their entirety by any single member of either group. Rather, the data we collected yielded narrative fragments that we have pieced together into coherent stories. The narratives we have constructed focus on the senior managers' and middle managers' perceptions of what they labelled *service development* and *management education*. These initiatives formed the core of a general strategy the chief executive described as being to 'develop the necessary pro-activity from middle managers towards the external environment in which they operate, and towards the utilisation of resources in response to that environment'. Service development consisted of two separate sub-initiatives, *business planning* and *marketing*. Business planning referred to those activities, conducted on an annual basis, by which Omega Hospital sought to assess its capacity for health care provision before it entered into negotiations with health care purchasers. In this process, the business development department produced a template to which middle managers worked in devising a series of business plans which were then negotiated and agreed with other managers, in consultation with ward sisters, team leaders and senior doctors. Marketing referred to a series of workshops that were delivered to middle managers by an external facilitator. These were designed to encourage them to be more marketing-aware in promoting hospital services. Management education took multiple forms, such as one-to-one mentoring with an external consultant, issue-based and skills-based workshops, and counselling.

Both senior and middle managers had plentiful opportunities to share their sensemaking and to work on their collective narratives. The senior

managers not only interacted in official settings such as board and ad hoc meetings, but also often shared coffee and lunch breaks. Although middle managers enjoyed fewer officially sanctioned opportunities for formal interaction, many of them were longstanding employees of Omega Hospital and, having previously trained together as nurses and worked in the same health care teams, they now often lunched together in the main hospital canteen. The management education and marketing workshops, which all attended, offered them further opportunities to renew old acquaintances and share understandings. One indication of their cohesiveness as a group was their election of two representatives to share their concerns with the senior managers.

Narrative imposition

Taking their lead from government policy initiatives, and sometimes quoting directly from policy documents that favoured the imposition of 'general management' on the NHS, the senior managers' narrative at first championed service development and management education:

> Sir Roy Griffiths reported that: 'if Florence Nightingale came back to a hospital today, she would not be able to identify who is in charge'. Our intention is to develop a cadre of middle managers who are in charge.
>
> (Organization Development Manager)

Seemingly convinced of the efficacy of a form of sectoral transference that favoured the import of private sector managerial practices into the hospital, senior managers argued that middle managers should identify with a management role, and concern themselves with the efficient and effective utilization of limited resources in their directorate. They recognized that this entailed a substantial change in orientation for middle managers, for whom managerial duties had, until recently, been a minor consideration. The senior managers were, nevertheless, convinced that they could make a success of the initiatives, and that these programmes would in turn catalyse changes in middle managers' attitudes and behaviours, making them more suited to strategy implementation:

> [For middle managers] the split was 80:20 in favour of clinical activity previously but is now 80:20 in favour of management activity.
>
> (Director of Human Resources)

> Currently, they [middle managers] are blockers to the changes required. We need to unlock the middle management as a lever for change.
>
> (Chief Executive)

The senior managers' narrative suggested that business planning was a rational decision-making system shifting middle managers' focus from narrow professional to broad patient interests, and which permitted the recognition of resource constraints over a longer time scale than had traditionally been the case. For senior managers, business planning was a means of extending their ability to control the allocation of scarce resources by co-opting middle managers into a set of systems geared towards achieving objectives prescribed by them. This, the senior managers argued, represented a radical departure from the past where:

> Resource decisions have been made by professionals [i.e. doctors] on the basis of what is best for the individual patient in front of that clinician. As a result an expensive but unnecessary drug treatment could be prescribed, which further depletes a limited budget.
>
> (Director of Nursing)

At this early stage the senior team maintained that middle managers had, to an extent, very quickly embraced business planning, and they were optimistic that their corporate strategy was being realized. Furthermore, they suggested that middle managers were responding to the wishes of those at local and national levels who funded clinical services. For instance:

> Managers in GUM [Genito-urinary Medicine] have put forward a business case for extra resources in their business plan because they are aware of additional funding opportunities nationally for HIV/AIDS infection.
>
> (Director of Business Development)

Senior managers suggested that the type of cultural change they were seeking to induce needed to be buttressed by a further set of initiatives designed to raise the profile of marketing principles within the hospital. They wanted middle managers to view marketing as a general philosophy with practical implications, which necessarily feature in public sector managerial life. In order to facilitate this they employed an external management consultant, to work alongside the business development manager, with the specific brief of encouraging the middle managers to adopt generic marketing ideas. They also began an extensive programme

of management education, again led by external management consultants, who were tasked with persuading:

> the middle managers . . . to move away from the old hospital culture to a new hospital culture. They need to change their way of doing things; to become champions for their role.
>
> (Director of Human Resources)

In contrast to the senior managers' account of this phase in the change process, the middle managers' narrative was much briefer. They portrayed themselves as being swept away in a torrent of new ideas and programmes:

> We just got swept along with it. We never worked out what our response should be.
>
> (General Manager: Critical Care)

Rather than either scepticism or resistance, the middle managers claimed to have met the service development and management education initiatives with studied neutrality. In their narrative, they listened to the external consultants outline marketing and general management principles with open minds:

> He [the external consultant] articulated his marketing philosophy . . . He then asked us, in groups, to discuss who the customer was.
>
> (General Manager: Medical Services)

> The management consultant claimed, 'management principles in the programme allow you to manage anywhere. It's transferable into any other organisation . . . management is about rationality so let's deal with the problem [resource allocation] rationally'.
>
> (General Manager: Maternity Services)

In these early days, then, middle managers presented themselves as willing to be convinced that business management was a self-evidently positive, and essentially scientific, approach to resource allocation problems in the hospital.

Narrative resistance

Within months, however, the middle managers began to make sense of, and to evaluate, the new initiatives in ways that the senior management team

described as resulting in 'a professional intransigence' (Organization Development Manager). The middle managers evolved a narrative that harboured doubts regarding the efficacy of some of the programmes, notably marketing and management education. They argued that they were primarily clinical professionals concerned with the care of individual patients, with only a secondary managerial responsibility for hospital resources. As professionals, with clinical knowledge and skills, they argued that they should have significant discretion in determining work activity in their areas. Their preferred scenario was one in which they contributed to both the broad approach and the specific detail of strategic change within Omega Hospital, so it fitted into the operational context in which patient care was delivered. They interpreted the transfer of management practices from the private sector to the hospital as unhelpful because this restricted their scope for discretion, and because no account was being taken of the uniqueness of the NHS context, or the distinctiveness of individual clinical directorates within the hospital.

The middle managers described how, within the business planning cycle, they had to produce a plan to satisfy the requirements of a template prescribed by senior managers. This document was, in effect, they felt, used to control rather than assist them, with the result that they felt 'dis-empowered' (General Manager: Medical Services). They argued that senior managers lacked an understanding of what occurred on the 'shop floor' (Service Manager 1: Medical Services) in drawing up a template for business planning. For example, in Accident and Emergency, 'you don't know what is going to come through the door, particularly with the elderly in winter, for example' (Service Manager: Accident and Emergency), yet the business plan asked for accurate predictions of service level on a monthly basis. As a result of variations in activity that the business plan could not predict, they felt that it was not a working (or workable) document: 'Instead we [middle managers] confine it to our bottom drawer' (Service Manager 2: Medical Services). Further, the middle managers' narrative made it clear that the internal market did not operate, as was assumed by the formal business planning process, with money following patients: 'In fact, money often doesn't follow patients' (Floor Manager: Surgical Services). Middle managers described how they had expanded activities with the result that purchasers had run out of money to pay for increased levels of activity. They cited the example of a ward in surgical services, which had been closed down temporarily, because service activity levels increased so dramatically in throughput terms that, mid-way through the financial year, local purchasers could not afford to pay for any more. In this case, physical space and consultant time and expertise had, they maintained, remained under-utilized until the new financial year began in the

following April, which did not seem 'very businesslike. The whole thing seems to be driven by private sector practices and the [questionable] assumption that allocating resources through the so-called market is best' (General Manager: Medical Services).

The narrative formulated by middle managers suggested that their situation had worsened, not least because the scope they had enjoyed previously to develop new business, and obtain extra funds, had diminished due to the financial constraints imposed by government, and intervention by the host health authority (the major local purchaser of health care). For example:

> We've been actively discouraged from taking any more GP direct access service business by the health authority. There's a limited pot of money and other directorates within our hospital or other hospitals lose out.
> (Service Manager: Trauma and Orthopaedics)

They also became highly critical of senior managers' enthusiasm for marketing, and the 'tight prescriptions' to which they felt subject. The middle managers described how the management consultant, who ran the marketing workshops, exhorted them to greet patients as 'customers' in a way they might expect in any other service environment. They described him as 'marketing mad' (Maternity Services Manager), and ridiculed his attempts to illustrate best marketing practice by making comparisons between the delivery of health care and the manufacture of baked beans, arguing that: 'we don't make anything. We provide health care to vulnerable people. It's serious. These marketing ideas aren't relevant' (Service Manager 2: Medical Services). While they did not dismiss marketing as a meritless activity, their narrative suggested that such activities had to be tailored to suit Omega Hospital. It was middle managers, they insisted, who were best positioned to judge what and where marketing activity was most appropriate. They cited clinical directorates, such as neurology and dermatology, with poor external reputations, that made marketing interventions ill advised: 'because it's down to the personalities of individual consultants over whom we have little control' (Service Manager: Theatres). Further, they maintained that medical consultants who had developed expertise performing a particular procedure, were highly likely to be resistant to the idea of doing something else, even if there was a market for it. In short, the power of medical consultants meant that there were huge constraints on what could be done in terms of marketing and making the hospital more like a business.

The middle managers' account of the management education programme was also extremely negative. They told of their concerns with the programme's general management (rather than specifically hospital management) approach

as the programme gathered momentum. They related how the programme facilitators had shown them a video that exhorted them to adopt a so-called 'paradigm shift', requiring them to assert themselves as managers. Their response, they said, was that 'you've got to temper that sort of message [about being a general manager in the private sector] with reality . . . it's about caring for people so we can't follow the cost-cutting principles of management as promoted in the industrial model' (Hospice Manager). But this was not done. Major deficiencies with the programme, they argued, were compounded by the facilitators' assumption that there were no essential differences between the private and public sectors, and their tendency to use examples from a manufacturing company in their teaching sessions. They were especially critical of the management 'competencies' that were promoted in the workshops, which they believed were not grounded in local hospital practices, and management consultants' prescriptions regarding how jobs should be designed and rewarded. They countered that:

> The elaboration and differentiation of professions means managerial control is limited and this constrains many managerial ideas on motivation. Also resources are constrained.
>
> (Service Manager 1: Medical Services)

In support of their views, the middle managers argued that many medical consultants openly backed them, and that at least one medical consultant had written to the chief executive on behalf of a middle manager:

> Sharon Ilkeston has been very disappointed with the Service Manager Development Programme and wishes to withdraw. She feels it has not been worthwhile adding little to her current knowledge.
>
> (Clinical Director)

Narrative confluence

Within 12 months of the start of the change project, while they remained convinced of the efficacy of business planning, the senior managers began to modify their story about the management development and marketing programmes. They suggested that they had learned from their experiences, and now realized that simplistic generic prescriptions needed to be replaced by context-sensitive initiatives that linked 'with their [middle managers'] world' (Chief Executive). They had, they maintained, responded to middle managers' concerns by marginalizing the management consultants responsible

for delivering the management education programme, and addressed the middle managers directly: 'We took over after nine months and asked middle managers, "what content do you want in the workshops?" ' (Organization Development Manager). Even the chief executive, they said, had met with the middle managers as a group and taken 'flak' (Human Resources Director), in a collective effort to 'link what was previously delivered by the management consultant to the state of play in the hospital' (Organization Development Manager). Similarly, the services of the management consultant responsible for facilitating the marketing workshops was, they said, dispensed with in response to the concerns voiced by middle managers. Moreover, they suggested that they had made a conscious effort to focus marketing activities on the more receptive clinical directorates, and to link marketing notions to patient care. For example, they maintained that a close working relationship had been built with the general manager for surgical services on the basis that 'there's room for competition in that area, at least around the margins of our [geographical] boundaries' (Director of Business Development).

The middle managers continued to assert that the principle of sectoral transference was problematic, but acknowledged that, at Omega Hospital, there had been 'a huge improvement, albeit a bit late in the day' (Maternity Services Manager). Their opposition to the new initiatives, which at one time had seemed almost total, began to fragment. The general manager in surgical services, for example, argued not that the service development initiative was flawed or irrelevant, but that 'it's a case of tweaking the concepts' so that they ensured 'a more efficient, effective and importantly, a customer-focused service'. The service manager in trauma and orthopaedics argued that the business planning mechanism was a reasonable means of allocating resources which prevented 'favoured consultants getting the money for their area and the rest of us not getting any', and described it as both 'more transparent and less political' than what had occurred in the past. In retrospect, two participants (out of 35) argued that the management development workshops had benefited them, and a few people claimed to have made effective use of the one-to-one mentoring scheme. Two middle managers who had joined Omega Hospital from the private sector even expressed enthusiasm for the change initiatives, and made comments in line with government policy, such as, '[we are] managers, not clinicians. Our job is to ensure resources are utilised efficiently' (General Manager: Trauma and Orthopaedics).

As senior and middle managers worked together on specific operational problems, and were able to exchange understandings, most respondents agreed that their views had become less polarized. Aside from the business

development manager, whose positive views on the change initiatives remained unaffected by events, the senior management team understood their narrative to have evolved. Both groups agreed that their main concern, 'at the end of the day, like everyone in the health service, is with the patient. We're all in this together' (Hospice Manager). The senior managers suggested that while they had made errors, the management consultants had largely been responsible for the crude efforts to import directly management practices into the hospital. They also argued that the problems associated with business planning were caused by the government's efforts to impose performance indicators on the NHS, but that these needed to be accommodated because 'to not meet the performance indicators would threaten our survival' (Chief Executive). They were adamant, nevertheless, that as a direct consequence of processes of change that they had initiated, Omega Hospital now offered a better service to patients and was better equipped to survive an uncertain future. Their view was that even if, as seemed likely, the hospital was merged with a neighbouring trust, 'we'll bring a lot to the party' (Chief Executive).

The middle managers recognized that the senior management team had attempted to address at least some of their concerns, and, like the senior managers, they made the management consultants and the government the scapegoats for many of the problems they had experienced. Rather than unthinkingly critique management practices as immoral, and question their role in a public sector institution, the middle managers claimed that they had come to appreciate their usefulness in providing a value-for-money NHS:

> We have to do what we have to do; go along with the government requirement.
>
> (General Manager: Therapy and Orthopaedics)

> It's taken a long time for me to think like this. It's only because I've worked closely with the Business Development Manager that I now see the sense of it all. It's all tied in with patient-focused care.
>
> (General Manager: Surgical Services)

> A major problem has been getting over this sort of moral hump that health professionals have. I think a lot of them think 'silly nonsense' and we don't need to bother about management. But they increasingly see that we have to be efficient because we are providing a public service with public money.
>
> (Primary Care Manager: Trauma and Orthopaedics)

Postscript

In 1999 the decision was made to 'rationalize' the provision of health services in the area served by Omega Hospital. In practice, this meant it became a community facility (rather than a full-provision acute hospital), and was soon stripped of its medical wards, theatres, accident and emergency department and critical care services. By the end of 2001 most of the senior management team had left Omega to take up other positions in the NHS. For example, the chief executive went to a prestigious teaching hospital, the business development manager took up a position with a private sector organization, and the organization development manager went to work for a health authority. All claimed that they, and others, had benefited from their experiences in attempting to manage change at Omega Hospital:

> We did a great deal at Omega. I hope some of our managers working for the new hospital are utilising the business management approach we adopted at Omega.
>
> (Chief Executive)

> The business management ethos I experienced at Omega helped in my case for the job.
>
> (Business Development Manager)

> There's a lot I learned at Omega that is helpful in what I'm trying to do here.
>
> (Organization Development Manager)

While many of the middle managers had begun to leave Omega after the rationalization decision in 1999, approximately half stayed on and were appointed to positions in the new management structure at least equal in status to those they had held previously. Interestingly, most of these agreed that, in retrospect, their experiences at Omega had been helpful to their careers:

> Those who left did well out of it. They took their business management skills elsewhere and got better jobs. Those who stayed got bigger jobs.
>
> (Former Service Manager 1: Medical Services, now Senior Manager in National Audit Office)

Discussion

To summarize, this article has sought to re-construct the distinctive narratives authored by members of Omega Hospital's senior managers, and middle manager cohort, in their efforts to read meaning into their working lives. More generally, this study has elaborated a view of organizations as storytelling milieux, in which narratives play important collective sensemaking, identity-defining, hegemonic, and legitimatory roles. In this discussion, the two narratives are re-examined in the specific institutional context of the UK NHS, and then used to illustrate how a narratological approach can assist researchers in their attempts to theorize processes of organizing.

A comparison of each group's narrative suggests a number of significant contrasts. Senior managers initially expressed favourable attitudes towards imported private sector practices, which they associated with improved efficiency and effectiveness. They also seemed to view middle managers as '[professionally] blinkered' (Organization Development Manager) policy-implementers, and argued that while some positive outcomes had been achieved at Omega Hospital, these had been mitigated by the intransigence of (some of) the middle managers. Middle managers always voiced more scepticism towards the principle and practice of sectoral transference, and placed greater emphasis on the tailoring of such practices to fit the unique context of a hospital. They argued that the initiatives had been ideologically rather than pragmatically driven, and considered that they should have more latitude to make adjustments and interpretations of policy utilizing their specialist knowledge of the clinical context. This said, not only were there tensions and divisions within each group but, over time, the senior managers' enthusiasm for the initiatives had waned while the antipathy of the middle managers had eased. Nevertheless, by the time data collection had come to an end the scope for a constructive dialogue between the two groups was still restricted by seemingly irreconcilable differences in perception. For example, while the director of human resources claimed 'I know what's going on because I go down to the wards and talk to those providing patient care', middle managers voiced the option that 'She [Director of Human Resources] swans in here, we roll out the red carpet to keep her sweet, she goes back to her office' (Service Manager 1: Medical Services).

In theory terms, we have used our case to implicate an understanding of organizations as pluralities of stories, and story interpretations, 'in struggle with one another' (Boje, 1995: 1001). Predicated on the argument that people are by nature storytellers we have argued that narratives are one symbolic category through which people create or enact (Weick, 1995) the 'reality' of organizations. This view of organizations is consonant with

March's (1996: 286) claim that 'The basic technology of organization . . . is a technology of narrative, as well as a technology of production', and Mumby's (1987: 113) assertion that 'Narratives provide members with accounts of the process of organizing'. Our approach explicitly embraces the idea that narratives play important sensemaking, identity-defining, hegemonic and legitimatory roles for both individuals and groups. As Salzer-Morling (1998: 116) asserts, 'In the fabrication of meanings lies a desire to offset heterogenization in meanings with homogenization, and thereby control and integrate people in the organization.' This, we contend, makes a narratological approach a particularly interesting means of seeking to understand processes of change in organizations. These arguments require further amplification and analysis.

Theorists such as Deetz (1986: 171) have suggested that it is language systems in general that 'provide an important interpretive frame for organizational perception and decision making'. For example, symbolic forms such as sagas, fantasy themes, metaphors, legends and folklore have all been attributed sensemaking functions. Many scholars, however, have argued that it is narrative, in particular, that is 'the primary form by which human experience is made meaningful' (Polkinghorne, 1988: 1). In our case, senior and middle managers told their different and partial narratives in order to make their experiences relevant, to contextualize occurrences, and to make connections between events in ways that made them seem coherent, unifying, and complete. The stories, and story fragments, that our respondents related to us in interviews were means by which they engaged in 'the never-ending construction of meaning' (Ng & de Cock, 2002: 25), and which were both emotionally involving and attention-provoking. These narratives were 'interesting forms of passing on knowledge' (Harfield & Hamilton, 1997: 67) between members of each group, that may have given their sensemaking perceptions a certain 'sharpness and richness' (Brown, 1986: 79). Perhaps most significantly, the fact that each group adhered to a different version of events suggests that the practice of narrative sensemaking involves both discovery and choice. As Fisher (1987: 65) notes, 'The world as we know it is a set of stories that must be chosen among in order for us to live life in a process of continual re-creation'.

Both as individuals, and as members of groups, our 'sense of personal continuity is grounded in the continuity created in the self-narratives one generates' (Slugoski & Ginsburg, 1989: 51). Not only do 'we make sense – or fail to make sense – of our lives by the kind of story we can – or cannot – tell about it' (Dunne, 1995: 146), but storytelling literally is 'the permanent re-elaboration of our identities' (Wallemacq & Sims, 1998: 129). According to Baumeister (1986: 322–5), in order to 'satisfy the basic requirements of

life's meaning', self-narratives should permit people to attach themselves to what they consider to be desirable ends, think well of themselves in moral terms, support needs for autonomy and control, and promote feelings of self-worth. In our case, these needs seemed to have been met relatively fully by the self-narrative of the senior managers, who depicted themselves as formally rational, in command, and responsible for significant positive change in the NHS. As the organization development manager asserted, 'Business planning is a strategy that allows us [senior managers] to manage the professionals'.

In contrast, the middle managers told a much more equivocal narrative, in which they had been distracted from serving the real needs of patients, and lacked the authority to make decisions. The middle manager narrative may thus be thought of not just as identity-defining, but as an oppositional strategy that both psychologically distanced them from the new policy initiatives through the expression of cynicism and detachment, and created an emotional and symbolic space from which they could critique their superiors:

> we provide health care to patients. We should not lose sight of that.
>
> (Hospice Manager)

> There is part of me that asks, 'why did I do my three years' training and ten years' working as a physiotherapist to push bits of paper around?' What should I really be doing?
>
> (Service Manager: Physiotherapy)

> They [senior managers] want a business manager whereas I am a specialist nurse who manages.
>
> (Service Manager: Trauma and Orthopaedics)

Organizations are socially constructed arenas in which groups struggle to maintain and protect their perceived interests through the active deployment of meaning. This is often referred to as the extension of hegemony, where hegemony 'involves the successful mobilization and reproduction of the *active* consent of dominated groups' (Clegg, 1989: 160, emphasis in original). Narratives are one means by which people seek to achieve hegemony, thus constituting other groups such that they are written out of particular scenes of power, resulting in their silence and inaction. As Mumby (1987: 113) notes, 'narratives not only evolve as a product of certain power structures, but also function ideologically to produce, maintain, and reproduce those power structures'. In this instance, the efforts of the government

to gain acceptance of the entrepreneurial model for the NHS, and of the senior managers in Omega Hospital to promote private sector practices, were only partially effective. Rather than unquestioning acceptance of sectoral transference as natural and fixed, journalists, academics, and hospital workers have authored a range of counter-narratives that have placed definite limits on successive governments' attempts to extend hegemonic control in this regard (e.g. du Gay, 2000). For example, complementing the narrative resistance of the middle managers in Omega Hospital are the various injunctions of scholars to recognize that entrepreneurial governance constitutes a 'one best way' framework that is arguably problematic (Elcock, 1995) and which may 'produce perverse results' (Self, 1997: 17). The views of the floor manager for surgical services at Omega typified those of middle managers in our case:

> A lot of people in the health service as a whole have felt, that many of the changes are based on impractical ideology. People who suggest these ideas don't consult enough with people on the ground who can say to them, 'the effect of business management will be this and it won't necessarily be good'.
>
> (Floor Manager: Surgical Services)

The narratives authored by the senior and middle managers, (versions of which are reconstructed here), were also means by which each group sought to legitimate its actions and interests. The point is that narratives 'may have as much to do with the self-legitimation of their narrators as with the relay of the information such narratives maintain' (Zelizer, 1993: 205). For example, patient care was almost universally regarded as a central value within Omega Hospital, and the fact that both groups' narratives represented themselves as motivated by it reflected a not surprising effort to draw on characteristics of their shared culture to legitimate their actions. The new policy initiatives were of particular importance to senior managers, for whom they were a vehicle for establishing the range of their legitimate authority by redefining what it meant to be a competent middle manager in an efficient and effective hospital; that is, an implementer of centrally imposed policies using a set of pre-defined management practices, in pursuit of more efficient patient care. The initiatives were also of considerable significance to the middle managers, who perceived their operational autonomy and discretion to be under threat, and who referenced patient care in order to support their critique of them. In practical terms, it was a shared concern for patients that most enabled a constructive dialogue between the two groups:

> They [middle managers] are closest to patients. They see the dilemmas and paradoxes of having to match the demands made to them by patients in beds and . . . with the performance criteria imposed upon them in the business planning framework, such as bed utilisation and contract targets. If anyone is the jam in the sandwich, it is them.
>
> (Organization Development Manager)

> They [senior managers] are in the same boat as us. They have slightly different masters in that they have to report to the health authority, but at the end of the day they do have patients' interests foremost in their mind. Like us they probably came into the health service to do something useful. It's the Government forcing them to implement business initiatives but at the same time, some of it is making sense. We've got limited resources to deliver patient service so we must use these well.
>
> (General Manager: Critical Care)

Conclusion

At a time when the linguistic turn in organization studies is attracting increasing attention, a narratological approach valuably and 'naturally situates language at the heart of understanding organization' (Westwood & Linstead, 2001: 3). The view of organizations outlined here has drawn on tropes such as Boje's (1995) Tamara metaphor and Rhodes' (2001) deployment of Bakhtin's notion of heteroglossia in order to theorize organizations as sites of plural meaning. In particular, following Giddens (1979: 188), we have sought 'To analyse the ideological aspects of symbolic orders . . . to examine how structures of signification are mobilized to legitimate the sectional interests of hegemonic groups.' Our approach has led us to incorporate three of the different ways in which narrative generally 'enters organizational studies' (Czarniawska, 1997: 26): the article has been written in a storylike way (Denzin, 1994), two 'tales of the field' (Van Maanen, 1988) have been represented, and organizations have been depicted as story-authoring social entities. This accords with our view that case study research of this kind, and the theories of organization on which it builds and to which it contributes, must be seen as practices of storytelling. It also provides the scope that interpretive researchers require to incorporate plurivocal understandings of events in ways that encourage polysemy to be read back into case study research.

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