UNIVERSITY OF BIRMINGHAM

Planes, straws and oysters

Millar, Ross; Dickinson, Helen

Link to publication on Research at Birmingham portal

Planes, Straws and Oysters: the use of metaphors in healthcare reform

Introduction

It has often been argued that public sector reform is 'predominantly achieved through policy-driven top-down change' (McDermott et al, 2013: 93). The National Health Service (NHS) in England represents a notable case in point as a highly centralised system characterised by top down policy directives. While such a view can be made of policy formulation, many studies of policy implementation note that any reform of healthcare systems requires change recipients to 'translate' national agendas into local contexts (Dickinson et al 2011; Millar et al 2013). Notable gaps in our empirical knowledge remain regarding how policy recipients react to and contribute to policy change initiatives, and the tactics they use to do so (McDermott et al 2013). One such perspective which is said to be in need of further development is the linguistic exchanges among actors as they negotiate meaning of organisational change (Thomas et al 2011; Hardy et al. 2005, Tsoukas 2005). This perspective has at its core the view that change programs often represent a "discursive template", as "a text produced by a particular author, which has to be interpreted by those whom it addresses in the context of specific local circumstances" (Thomas et al 2011; Tsoukas and Chia 2002).

The purpose of this article is to present research findings that focus on the metaphorical language used to express the implementation of healthcare reform policies in England. We build on a view of reform as a "multi authored" process (Buchanan and Dawson 2007), showing how metaphorical language is often used to explain the consequences, challenges, limitations, and

1

opportunities associated with particular reform proposals (Cornelissen *et al.*, 2011). Such a view can be connected to what Thomas et al (2011) summarise as the perspective of "organizational becoming". This perspective calls into question traditional conceptions of resistance to change whereby resistance to organisational change can play a facilitative role in creating 'generative dialogue' when proposals by senior managers or change agents involve challenge and modification by other employees (Ford et al. 2008). Thomas et al (2011) suggest that such a standpoint seeks to move beyond the view that resistance to organisational change is solely associated with degenerative dialogue that often reinforces existing power relations, the imposition of meaning, and prevention of new knowledge being produced.

In this paper we analyse the sorts of metaphors used by senior managers and clinicians to describe the experience of healthcare reform. It provides the first systematic study of patterns and meanings of metaphors within English NHS and beyond to argue that metaphors have the capacity to illustrate both the generative and degenerative dialogue associated with organisational change. The paper begins with an overview of debates regarding healthcare reform. This is followed by a focus on the particular communicative practice that is the focus for the article – the use of metaphor within the context of healthcare reform. A review of the metaphor literature is then summarised before going on to present the metaphors used by actors to understand different policy reforms and their implications for organisational change.

Healthcare reform

Much of the mainstream policy implementation literature has debated whether policy is (or should be) given to local areas to implement in a top-down fashion, or shaped, developed and

designed from a bottom-up perspective (Dickinson, 2011). Alongside these debates, there is a significant and growing literature concerning policy implementation within healthcare which goes beyond seeing this complex process in a simple binary fashion (e.g. Dickinson and Mannion, 2012). These recent studies illustrate the complexities of the health reform process and note the different opportunities and constraints for organisations and employees to act within. For example, McDermott et al (2013) in their study of implementation across four hospitals in England and Ireland highlight the entrepreneurial responses to policy by change recipients as they identify and act upon opportunities for their organisation. Their findings challenge the view that all non-adopting responses to change constitute 'resistance' (productive or otherwise) is largely negative. Their findings also highlight how context or 'contextualized change agency' has the ability to enhance or deny successful implementation of these change efforts (McDermott, et al 2013; Robert and Fulop 2014).

The introduction of market based incentives designed to encourage competition and choice in the English NHS represents an interesting case in point regarding the process of organisational change (Greener et al 2014; Mays *et al.*, 2011; Allen, 2009). Over recent years policies have been introduced with the aim of creating patient choice of providers as a lever to drive up standards; increasing the diversity of private, public and third sector providers to promote greater innovation and responsiveness; promote 'Payment by Results' to improve quality by charging each episode of care at national tariff rates; and create a variety of arms-length agencies to oversee and hold NHS organisations to account. A variety of research has been carried out on these reforms and their impact on healthcare organisations (Mays *et al.* 2011; Powell *et al.* 2011). In particular, some of these studies show how local contexts shaped the design and

implementation of the reforms that determined the nature and extent to which they were put into practice (Coleman *et al.*, 2010; Mays et al 2013; Millar et al 2013; Dickinson 2011). In addition, studies have also shown how recent reforms have been associated with top down managerialism governed by performance targets and regulation. Currie et al (2009) for example notes that while recent leadership programmes in England have sought to promote distributed leadership, target-based leadership focused on individual accountability has tended to prevail (Dickinson 2014; Currie and Lockett, 2007; Currie *et al.*, 2009).

Given the importance of national and local actors in the process of health reform, our interest in this area draws attention to the idea of 'organisational becoming' (Tsoukas and Chia, 2002). This perspective treats organisations not as fixed entities but as emergent and unfolding enactments that are shaped by local actors engaged in their local work (Thomas et al, 2011). Furthermore, it sees organisational change as the result of a series of ongoing linguistic exchanges between the various actors involved (Ford and Ford, 1995). Our focus on reform within local healthcare contexts looks to draw to this perspective with a particular interest in the tensions associated with reform and the extent to which this can negotiated and overcome (O'Reilly and Reed, 2011). The following sections outline how we focus on the use of metaphor as way of illustrating this perspective.

Studying organisational metaphors

The perspective of "organisational becoming" as summarised by Thomas et al (2011) has a number of crossovers with the established tradition of studying paradigms, schemes and metaphors within organisational contexts (Cornelissen et al 2008; Grant and Oswick 1996; Putnam and Boys 2006). Interest in metaphors has been on the basis of them being central to human discourse and understanding (for example, Cassirer 1946). Often seen as central to work on organisational theory and the theory-building process (Tsoukas 1991; Weick 1989), metaphors can guide perceptions and interpretations of reality. They can also facilitate and further our understanding of organisations as they help us to formulate visions, goals and activities (Cornelissen et al 2008). When we attempt to understand organisations we often use metaphors to make them compact, intelligible and understood.

In what can be most famously traced back to the classic work of Morgan, his metaphors of organisation provide a classification and set of diagnostic questions that aim to reveal 'the assumptive ground' of organisational life (Putnam and Boys 2006; Morgan 1980, 2006). These metaphors (such as machines, organisms, domination) assume that the understandings flowing from them are rooted in the socially shared reality of theorists, managers and employees, and express shared ways of thinking about organisations. By being open to the frames and concepts generated by these different metaphors, Morgan (2006) argues that we open ourselves to a variety of insights and creative interpretation.

A variety of research about metaphors has been produced. Cornelissen et al (2008) summarise how these studies have ranged from those that impose (or 'project') on to organisational reality to those metaphors that naturally surface within the talk and sensemaking of individuals (Cornelissen et al 2008). In relation to the latter, Schlesinger and Lau (2000) describe how both public and political elites often comprehend complex policies in part through "reasoning by policy metaphor" in their comparison between proposed policy alternatives. Cornelissen et al (2012) summarise how sensegiving within entrepreneurial contexts can draw on metaphors in speech and gestures to compress uncertain and complex ventures into familiar categories. Here, the use of metaphors can enable individuals to emphasize to others the predictability and taken-for grantedness any new proposals as well as provide opportunities for entrepreneurs to exert their own agency and control. Metaphors can also increase the ability of constituents to make sense of a new venture by reducing uncertainty as well as increasing confidence.

In their review of the strategic change literature, Cornelissen et al (2011) outline how metaphors have often been deployed to communicate cross-categorical comparisons. Strategic change is often likened to other cultural domains of experience outside a specific corporate or business context, such as sports or arts, as a way for members of an organisation to comprehend changing and unfamiliar situations (e.g. Gioia, 1986; Gioia et al., 1994). Cornelissen et al (2011) also suggests that these metaphors can produce links to action, as they structure situations into an understandable format, and can produce socially justifiable decisions and actions to others by validating some accounts while discrediting others.

Cornelissen et al (2012) summarises that up to now most research on metaphors in entrepreneurial contexts has focused on how venture creators use metaphors to describe the general phenomenon of entrepreneurship or described with cultural metaphors such as journey, theatre or warfare. There has to date been very little direct research on how metaphors are used by individuals to give sense or direct the interpretations of others regarding organisational change. This is despite the well-established view that metaphors are often seen as crucial to individuals as they make sense of their own ideas. Within healthcare, some of the established metaphors of organisation have been applied to healthcare contexts to understand the nature of organisational change (Elkind 1999; Millar 2009). Yet these applications do not go beyond the established repertoires of organisational metaphors into a more detailed and contextualised understanding of how and where metaphorical language is used within healthcare settings.

A wider review of the literature in healthcare shows a variety of research has analysed the use of metaphors within the narratives and stories of illness. These have illustrated how metaphors are often deployed to bridge the gap between experience and the world of technology and treatment, as patients make sense and give sense to their illness (Annas 2011; Laranjeira 2013). For example, McFarland et al (2009) identified how a chronic disease self-management course used metaphorical language to help course participants identify their own feelings and construct meaning of their illness. Tutors used metaphors as a way to conceptualise emotional states that course participants found difficult to label. Arroliga et al (2002) found that metaphors had the ability to enhance communication when explaining pulmonary illness. Patients were able to draw on a variety of natural, mechanical and somatic images to express the impact of pulmonary diseases.

Metaphors in healthcare have also featured as a key part of policy and political life. The early work of Annas (1995) draws attention to commonly used metaphors in the US. He suggests that the traditional metaphor of American medicine has changed from a military metaphor to a market metaphor in the reform of financing healthcare insurance. Annas (1995) summarises that the market metaphor builds on an image of healthcare as the marketing of products to consumers who make choices on the basis of price and satisfaction. Healthcare advertising and competition among suppliers ensues with the primary motivation being profit along with a drive for efficiency, customer satisfaction, and entrepreneurship.

Annas (1995) summarises that the market metaphor provides a powerful image, yet many of its assumptions struggle within healthcare contexts. In particular, the ability of patients to make consumer decisions and the ability of the market to distribute goods and services unrelated to price (Malone 1999). Hudak (2003) reflects on the metaphor of "patients as customers" illustrating how it seems reasonable to ask patients to rate their satisfaction with the processes of care or services received (e.g. hospital food, the physical environment) in much the same way they would rate services received as a repair shop or restaurant. Yet when evaluating treatment outcomes, Hudak (2003) suggests that the customer metaphor is problematic in treating the body as an object or as a repairable possession. The customer metaphor does not consider the wider psychological, social and experiential aspects of treatment outcomes

Alongside the market metaphor, the military metaphor in healthcare can still be identified in the everyday images of medicine as a battle against death, a war on disease, the heroic nature of professionals, and brave patients' "soldiering on" (Annas 1995). Key elements of the metaphor

can be found in medical research (Annas 2011), issue campaigns such as the "war on cancer" (Sontag 1977; Penson et al 2004), and the metaphors of bio risk such as foot and mouth disease and SARS.

Despite these market and military metaphors continuing to dominate, Annas (1995) suggests new metaphors are needed with the leading candidate being ecology. The metaphor of ecology evokes words such as balance, limited resources, and diversity that help us confront and accept limits (both on expectations and resources), value nature, and emphasize the quality of life. The perspective also puts more of an emphasis on individual risk factors, more emphasis on prevention, public health interventions, and standards that provide a greater role for ethical behaviour. Such an image resonates with current interest in integrated care (Bousquet et al 2011; Goodwin 2012) in its aim to bring different actors together in collaborative relationships in the delivery of patient care.

Methods

Our research focuses on metaphorical language used by healthcare to express the effect of market reform policies in England. The research formed part of a wider study of health reform in England (see Powell et al 2011) which carried out semi structured interviews with actors leading secondary and primary care organisations to understand the experience of market reforms across different organisational contexts. These actors occupied senior management and

clinical positions within their organisations and had strategic responsibility to enact local policy responses. The sample included Chief Executives, Directors of Operations, Strategy, Medical Directors, Lead Clinicians and Consultants of specialities. A semi structured interview guide was constructed to capture various aspects of reform that included their understanding and interpretation of how various policy measures worked in practice and how they negotiated any tensions associated with delivering them. All interviews were recorded and transcribed with the NVivo computer programme used to manage and code the transcribed interview text.

The research identified a variety of interpretations of health reform and how these were being delivered locally (Millar et al 2013; McLeod et al 2014). Out of the 174 interviews with these actors, in 12 of these interviews our research identified some notable instances and scenarios where metaphorical language was being employed to communicate how reforms were experienced and the implications they had for organisational contexts. As this became a feature of the fieldwork, we captured these expressions during data analysis where passages of text that illuminated particular metaphors were placed into an open code created using the NVivo software. Our definition of metaphor in this respect was as a figure of speech in which a word or phrase which applied to something to which it is not literally applicable (Ox Eng Dictionary; Pragglejaz 2007). This definition of metaphor contrasts with the literal and basic sense of words in the context of a spoken or written sentence in line with Lakoff and Johnson's (1980) starting point of metaphor as 'the understanding of one thing in terms of another'. We built on the methodological approaches of others in this area (e.g. Cameron 1999; Steen 1999) by working through a transcribed text and identifying for each sentence or utterance all those words and expressions that activate meaning 'which cannot be literally applied to the reference in the world evoked by the text' (Steen 1999: 61). The eventual selection was on the basis that they seem to

effectively illustrate the different ways in which the reforms were framed and capture the locally-specific uses and meanings of metaphors (Cornelissen *et al*. 2008).

Findings

Our findings highlight how healthcare managers and clinicians employed a variety of metaphorical language to communicate how their organisations were able to enact and resist market based reforms. On the one hand, these metaphors were an attempt to illuminate the limitations of these reforms within organisational contexts. Yet they were also an attempt to reflect how different reforms created opportunities and space to develop local service improvements. Whilst the former categories highlighted the negative consequences of market reforms, the latter group framed the proposed organisational changes in a more positive light (Table 1). The following section details these two categories starting with the limitations of reform followed by the opportunities these proposals could create.

Table 1. Summary of metaphors associated with healthcare reform

Metaphor	Explanation
Reform as 'Planes'	Healthcare reform too unpredictable and risky for market conditions.
Reform as 'Fastfood'	Health reform associated with the standardisation and specification of practices.
Reform as a 'Supermarket'	Healthcare reform incompatible with contexts that lack the necessary information and pricing methodology to enable market exchange.

Reform as 'Noise'	Healthcare reform levers and incentives in tension with ends to achieve better care and better value for money
Reform as 'Schizophrenia'	Healthcare reform creates internal tensions associated with leadership identity.
Reform as 'Grit in the oyster'	Healthcare reform creates 'constructive discomfort' for change and improvement to happen.
Reform as 'Straws in the air'	Healthcare reform creates a space for action to seize the moment for service improvements

Planes and supermarkets: the limits to top down change

Senior managers and clinicians highlighted a number of difficulties and limitations in the reforms to promote market competition and patient choice. These perspectives focused on particular instances and scenarios that illustrated how local contextual circumstances meant it was not possible to have a 'true' market. The quote from a Chief Executive below illustrates this, using metaphorical language to highlight the differences between healthcare contexts and other service based industries. In contrast to these other industries, healthcare, in their opinion, did not have the necessary conditions required for a market to flourish. Indeed, greater choice and competition in healthcare services could be problematic.

"They want the choice and the contestability and the drive for improvement, without having the downside of what markets are like... that is that you can't get into your restaurant, the supermarket runs out of beans, you know, that's what markets do"
(Foundation Trust Chief Executive 2)

This was a point also illustrated in relation to instances where patients were given greater choice to select which provider they went to for hospital procedures. The 'choose and book' policy was a process introduced to allow patients to select times and dates of appointments as well as providers. Compared with other industries, healthcare was seen as too unpredictable and too exposed to risk to implement 'market conditions'. Here, the examples of booking and flying on board an air flight were used by two Chief Executives to illustrate what they see as the incongruity between ensuring patient choice and a system that runs as efficiently and effectively as possible and within a defined budget:

"When you book your flights you look at where you want to go, where you want to fly from, what times you want to fly etc but you often don't get a complete match available. You then compromise on which of those areas are more important to you e.g. airport or cost. In health it feels like we have to meet all requirements and if we don't, the assessment criteria criticises our quality of care, yet it is equally impossible sometimes to get the right Dr, time, waiting period, location in place!" (Foundation Trust Chief Executive 1)

"I missed my flight on holiday two years ago and I went up to the desk and said 'I've missed my flight, I'd like another one' and do you know what they said to me, they said 'there aren't any', they didn't say 'certainly, madam, I'll put another plane on for you', which is what we have to do and, you know, I got another flight in the end and I didn't go with the one I booked with, I went with British Airways and it cost me fifteen times more,

you pay a premium for scarce service and yet we're trying to make it like a market, but it's not like a market, because that would be terrible, you can't possibly have people not getting their flights, can you?" (Foundation Trust Chief Executive 2)

Despite the fact that the rhetoric of the reforms was that they should be 'decentralising' and free up organisations to deliver locally responsive services, our findings also described how in fact some aspects of the reforms had centralising tendencies. Rather than being 'bottom up', the reforms were 'top down' in their standardisation of local services. In the case below, a senior clinician employed fast food imagery to reflect the standardisation and specification of practices associated with reform. The specific policy example concerned the implementation of new information technology; *Connecting for Health* which was designed to support delivering computer systems and services to improve patient information storage and access. For these interviewees, the implications of implementing such a policy were to overhaul local information systems that were in fact seen as more viable. These types of nationalised systems were seen as impeding local practices and were therefore to be resisted.

"Connecting for Health … it's sort of money thrown out from above, there's no proper business case or anything is there… we don't have any choice about the provider, so the provider arrives so we're basically in the position of a branch manager in Kentucky Fried Chicken that somebody in Atlanta has decided what software you're gonna have and you have to implement it… but actually, the viewing system that we have is not as good as free Shareware ones that you can get off the internet" (Orthopaedic Consultant 2)

The introduction of transactional changes aimed to facilitate competition between providers through 'Payment by Results' also proved to be a challenge. The move to 'payment by activity' was interpreted as problematic within contexts not favourable to such market exchange, particularly as local contexts did not have the necessary 'level playing field' for market transactions to take place. This argument is illustrated below by a chief executive and medical director working in different hospital organisations. Their purpose is to highlight that transactions in healthcare contexts are much more complex than in other service industries and contexts. As a result, systems lacked the necessary information and pricing methodology to enable market exchange.   These problems with transactional reform were illustrated by comparisons with buying food products from a supermarket

"... it's the buying a can of beans at the supermarket, isn't it? you know, I could get a better can of beans more quickly when we had two supermarkets than one, but I'm not buying a can of beans…. if all the tins are the same price, and if you tend to sell more expensive tins, you're not doing very well, compared to a hip and knee factory which is selling beans and doing very well, thank you very much. So the whole idea of HRG [Healthcare Resource Groups] is it brings more prices in that are more reflective of the work you really do. But, …they really haven't allowed us to keep up and also what the policy for PBR says is that we should move away from costing based on an average cost, to being based on better practice, so they should work out, you know, the good rate is cheaper, bring them in on the day of operation, do the hip, discharge them the next day, five physio appointments, whatever it is, that's a good package of care, let's work out

what that would cost, that's the price. And if you're doing something more elaborate than that, you're going to lose money... so they're overusing the demand and supply again and not really supporting it by a good pricing methodology anyway.

(FT Chief Executive 3)

So you know, you're going into Tescos and saying, "I am going to bung you 5 quid, you supply all of my grocery needs for the next week please", is not a very common way of doing business. You go into Tescos and they've got a range of things at different prices, so you can have the basics or you can have the finest...then you go to the counter and you pay for what you've done. Now, we are at the level of our commissioners come in and bung us a fiver and say "can you do my weekly groceries for that please". And they may not be happy with what we give them for a fiver because we say well that's all your fiver is going to buy you and we may not be happy that a fiver actually covers the cost of their weekly groceries, even if we put all the basics in there. So it is a hopeless system (FT Medical Director)

The difficulties of introducing transactional reform in the form of payment by results was further illuminated in relation to the prices set for each activity. For those occupying clinical secondary care settings, particular concerns were raised about having the necessary information in order to calculate the appropriate price:

"The Canadians know the price of everything that they do... Whereas the NHS has never been like that...It's very difficult to put a cost on the thing because actually we

don't know the cost of anything, we've no idea and most Trusts have no idea… In fact the general feeling is now for knee replacement particularly they've cut the value, cut the reimbursement so much that actually if we were a business… you would just say actually it's not worth stocking those Cadbury's chocolates because they… cost too much, we're not allowed to sell them for that. Or alternatively you can say actually we offer a premium service and therefore we will charge a premium price and you can't have centres that push innovation, research and training, say and actually financially we're a loser" (Orthopaedic consultant 1)

The images presented above illustrate some of the metaphorical reasoning employed to illustrate the consequences and challenges brought about by reforms encouraging market modes of organising. In particular, these perspectives draw attention to their inherent limitations, the incongruent nature of the reforms based largely on the inability to be able to control demand, supply and transaction costs within organisational contexts. This gap between means and ends was illustrated by a senior manager who referred to the reforms as 'noise'. The goals were sensible, however the reforms that were aiming to provide levers and incentives for service improvement actually got in the way of leading.

"I think the bit in the middle [Better care, patient experience and value for money] is right, I think the argument is about whether the things around that are the best ways of achieving the bit in the centre. I think ...why did I go into health care management? It was about the thing in the middle and I think how I get it is in a sense for me to make the best use of the money that's available to the population. So I would say quite a lot of the

stuff around this is noise to be navigated rather than things that particularly help me do my job better… a lot of these things actually don't connect properly in my view and there are probably easier ways of achieving the objective" (FT Director of Strategic Development)

'Grit in the Oyster': the opportunities for organisational change

In contrast with the images presented above, a second group of metaphors were used to evoke the opportunities and possibilities associated with leading reform across particular contexts. These described how market reforms had created tensions in the act of leading. Such a view was exemplified below by a Director who referred to the 'schizophrenia' associated with their leadership role:

"I think a lot of the reforms have been very powerful and I think the, putting the patient first has been one of our strategic objectives since '98 but, you know, the fact that we are going to design services around patients, we want to get integrated services in proper pathways and partnerships, I think it's hugely important. So there's a lot of the reform that I feel very comfortable with, but I think my own schizophrenia happens when I quite often meet with the Department of Health and depending which bit you meet with, you know, 'you're just a provider and you should do as you're told'. Or, actually, it's about whole systems partnership and when there's, you know, you mustn't act like a provider who says 'sorry, you know, not my problem, you haven't commissioned enough activity' or whatever. So it's not so much some of the principles… the principles are fine and

probably unchallengeable. It's how they feel when you do it" (PCT Director of strategic commissioning)

In contrast with the images of reform as negative and incompatible, our sample also illustrated how the reforms created conditions of 'constructive discomfort' for change and improvement to happen. The reforms created a space for action that was exemplified in the metaphorical comparisons below:

"One of my concerns about the reforms is that there is not a split between commissioning and providing so we have worked in some areas we've worked in competition to the private sector and sometimes we've worked in co-operation with them and I think... you can be competitive in some areas of your business and, actually, working in partnership's greater value in another... I think, in principle, you know, the idea that you have to break the monopoly and you have to put some grit in the oyster, I think it did change and it changed our consultants' attitudes and to that degree it was very positive" (Director of Strategic Commissioning 2).

"yeah, I can see that, you know, again, in terms of a grit in an oyster kind of scenario, it doesn't have to be everywhere, it doesn't have to be everything, it just has to be enough to make people, hmm, let's, we better sort our ideas out" (FT Chief Executive 3).

Such critical reflection about the reforms and the potential opportunities these could bring were developed by those predominately working in commissioning, primary care organisations. These

perspectives suggested that in contrast to being passive recipients of top down reform, they sought to 'seize the moment' created by the reforms. The following example provided by a senior clinician demonstrates how this change could occur. They use the metaphorical image of 'tossing straws in the air' to demonstrate the potential of reform as 'cracks open' for service development to occur.

"It depends on one's attitude towards change, because you could if you wanted to, baton down the hatches, pull down the sails... The flip side to that...is all the straws have been thrown up in to the air, how are they going to fall? Perhaps we can influence the way that they fall and actually influence the way things are in the future... I think that the reforms are in many ways quite damaging, but on the other hand there are little cracks which open up for you to kind of shove a little bit on and kind of lock away until that crack opens up and develops something. So what I think of the reforms...they're fairly destructive to long term conditions, but on the flip side, I can see that there are opportunities which we need to grab. ... I guess the changes have been useful in that it creates an air of uncertainty, so it's tossing those straws up in the air, so that we can change things." (Diabetes Consultant)

These contrasting images of constraints and opportunities associated with reform draw attention to central debates concerning leadership of healthcare organisations. While one group of metaphors largely support what has been documented elsewhere: namely, that efforts and capacity to decentralise and lead within healthcare organisations has been restricted by

contextual constraints and target based on centralised accountabilities (Currie et al 2009); this latter group of metaphors demonstrate the potential of reform to create the capacity to lead and create service improvements by providing the 'grit in the oyster' (O'Reilly and Reed 2011).

Metaphor and the negotiation of healthcare reform

Our findings presented above highlight the metaphors used by senior managers and clinicians as they attempted to negotiate reform within particular organisational contexts. They show how these metaphors could be clustered into two types of communicative practices. The first being an attempt to illuminate inherent limitations within these policies and the second being an attempt to illustrate the opportunities reform could bring as a source for critical reflection and opportunities for improvement.

The implication of these findings talk directly to the view of Thomas et al (2011) in showing how particular communicative practices can lead to different dynamics in the negotiation of meaning related to organizational change. The metaphorical images associated with booking an air flight to describe the policy of patient choice and the stocking of a supermarket to illustrate payment by results were done so to illuminate how conditions of market transaction and supply and demand were incompatible with existing healthcare contexts. They provide a strong linkage to limits of managerialism and the incompatibility of market mechanisms within healthcare contexts. In this sense these metaphors draw attention to what Thomas et al summarise as dialogue that is "degenerative" (Gergen 2004). These metaphors were suggestive of reform that

was imposed, minimally cooperative, and at times conflict ridden. Action within these contexts was also more likely to be in the form of enforced compliance with implementation associated with a dismissing, deploying authority, and hierarchy. Interestingly, these metaphors also showcase the demarcation between reforms and organisational contexts: there was little or no way to bridge the two meanings together.
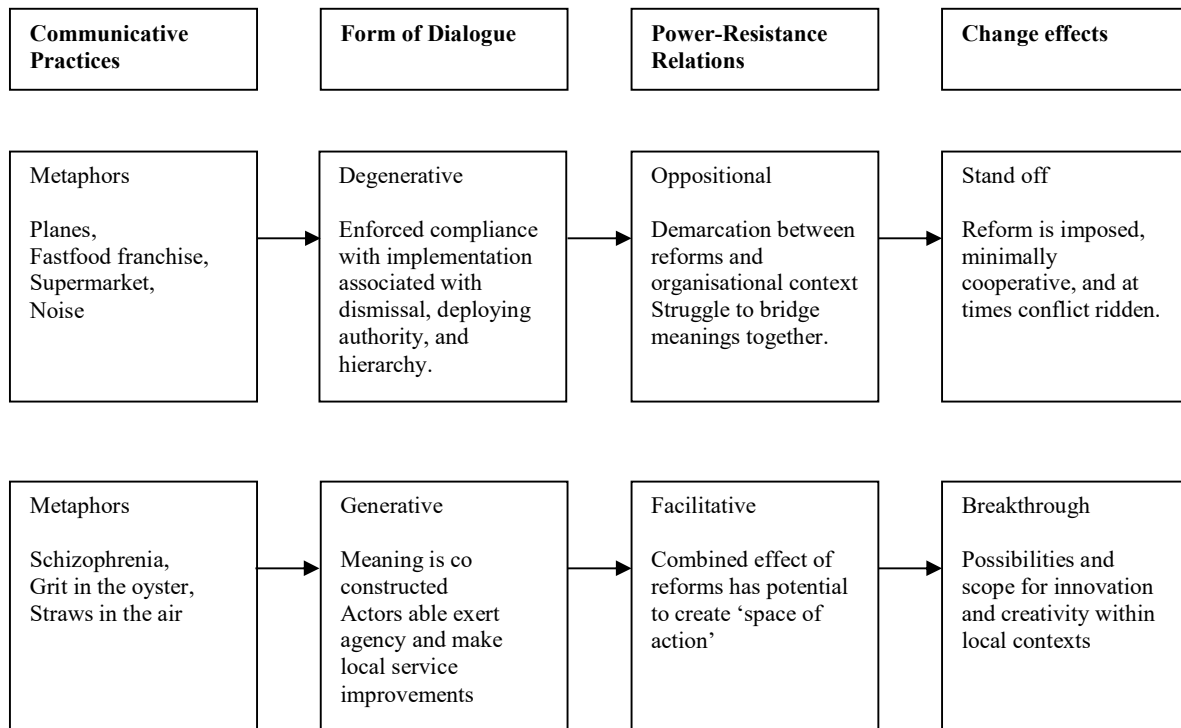
In contrast, the metaphors drawing attention to reform as the 'grit in the oyster' show the possibilities and scope for innovation and creativity within local contexts. These metaphors show evidence of 'leaderism' (O'Reilly and Reed, 2011) whereby elements of the proposed reforms could enable new practices and local service improvement. In doing so, these metaphors give some credence to the view that meaning which is co constructed through dialogue can be "generative" (Gergen et al. 2004) in bringing about innovative and synergistic organizational change. The combined effect of the reforms has the potential to create a 'space of action' in which to exert their agency and make local service improvements (Fairhurst, 2009).

Both these groups of metaphors make important contributions to our understanding of the dialogue and conversations associated with managing change. They provide insights into the types of specific communicative practices that may lead to different outcomes depending on the context in which it is used (Figure 1). Interestingly, when we compare across these accounts we find subtle contrasts in the images employed by actors from different parts of the system. The metaphorical images differed between leaders in secondary care and primary care contexts for example. The mechanical imagery of airports, supermarkets and fast food drawing attention to the dysfunctional and dehumanising elements of reform was more likely to be employed by

secondary care leaders within hospital settings. In contrast, the images of schizophrenia, grit in the oyster and straws in the air reflected those working within primary care settings. To some degree this might be expected given that many of these settings predominantly deal with inpatient acute and elective care, whilst the raison d'être of primary care is arguably more outward facing in addressing the needs of the health community and healthcare prevention.

These contextual differences open up important future lines of inquiry particularly in relation to how and where particular uses of language can explain the reform of healthcare organisations. Building on earlier work in the area of meaning negotiation (McDermott et al 2013; Thomas et al 2011), our study provides a number of insights into the resistance in organizational change, showing how resistance can play a facilitative role in organizational change through conceptual expansion, combination, and reframing. Furthermore, these findings go some way to providing a new contribution to the field of studies drawing attention to the importance of metaphors in healthcare organisations. The metaphors that we encountered draw attention to the important limits of rationalist mechanisms and frameworks in the context and delivery of complex human systems. In this sense, metaphorical images, like narrative itself, can potentially mediate the subjective and objective experience of organisational life (Currie and Brown, 2003; Newman et al., 2006; Needham, 2011) in capturing the personal, institutional and social dimensions of healthcare delivery (Hurwitz *et al.*, 2004).

Figure 1 Dynamics in the negotiation of meaning about healthcare reform (adapted from Thomas et al 2011: 34)

Communicative Practices	Form of Dialogue	Power-Resistance Relations	Change effects
Metaphors Planes, Fastfood franchise, Supermarket, Noise	Degenerative Enforced compliance with implementation associated with dismissal, deploying authority, and hierarchy.	Oppositional Demarcation between reforms and organisational context Struggle to bridge meanings together.	Stand off Reform is imposed, minimally cooperative, and at times conflict ridden.
Metaphors Schizophrenia, Grit in the oyster, Straws in the air	Generative Meaning is co constructed Actors able exert agency and make local service improvements	Facilitative Combined effect of reforms has potential to create 'space of action'	Breakthrough Possibilities and scope for innovation and creativity within local contexts

Concluding remarks

A study of metaphors in the context of healthcare reform has highlighted some of the ways in which meaning unfolds during conversations and illustrations of organisational change. By drawing attention to the problems and opportunities associated with market based reform, these metaphors illustrate some the creative and innovative meanings shaping the actions associated with organisational change. In doing so, we hope that our paper contributes and encourages

further research about the use of metaphors to understand the nature and impact organisational change within healthcare settings.

There are some potential limitations with the study. Our use of metaphor is susceptible to the point raised by Cornelissen et al (2008) about the pitfalls made by scholars who extrapolate too readily from identified metaphors in a text to a suggestion of systematicity in metaphor use. Furthermore, it is susceptible to criticisms made by Down and Warren (2008) that the use of hyperbolic metaphors to characterise entrepreneurial activities may further de-contextualise speech in natural contexts of communication. In response to these possible criticisms, our study has ensured that wherever possible the metaphors selected have been connected to their respective organisational contexts. Our metaphor identification and selection was also compared between analysts and connected to external sources identified in the literature.

Acknowledgment

References

Allen, P. (2009), Restructuring the NHS Again: Supply Side Reform in Recent English Health Policy, *Financial Accountability & Management,* Vol 25 No.4, pp.373-389.

Annas, G.J. (1994), Reframing the Debate on Healthcare Reform by Replacing Our Metaphors, *New England Journal of Medicine*, Vol 332, pp. 745 – 48.

Annas, G. J. (2011), The Two- Eyed Cyclops: Metaphor and Narrative in American Medical Research Policy, *Genre*, Vol. 44, No. 3, pp.393-403.

Arroliga, A.C. Newman, S. Langworth, D.L. (2002), Metaphorical Medicine: Using Metaphors To Enhance Communication with Patients Who Have Pulmonary Disease, *Annals of Internal Medicine*, Vol 137 No. 5, pp. 376-380.

Bousquet, J. Anto, J.M. Sterk, P.J. Adcock, I.M. Chung, K.F. Roca, J. et al. (2011) Systems medicine and integrated care to combat chronic non communicable diseases, *Genome Medicine*, 3, p. 43

Buchanan, D. and Dawson, P. (2007), Discourse and audience: organizational change as multi-story process, *Journal of Management Studies*, Vol 44, pp. 669–686.

Cameron, L. and Low, G. (1999), *Researching and applying metaphor*, Continuum International Publishing Group: New York.

Cassirer, E. (1946), *Language and Myth*. Harper and Brothers: New York.

Coleman, A. Checkland, K. Harrison, S. and Hiroeh, U. (2010), Local histories and local sensemaking: a case of policy implementation in the English National Health Service. *Policy and Politics,* Vol 38 No. 2, pp. 289–306.

Cornelissen, J.P., Oswick, C. Christensen, L.T. and Phillips, N. (2008), Metaphor in Organisational Research: Context, Modalities and Implications for Research – Introduction, *Organisation Studies*, Vol. 29 No.1, pp.7–22.

Cornelissen, J.P. (2005), Beyond compare: Metaphor in organisation theory, Academy *of Management Review,* Vol 30, pp. 751–764.

Cornelissen, J.P. Holt, R. and Zundel, M. (2011), The Role of Analogy and Metaphor in the Framing and Legitimization of Strategic Change, *Organisation Studies*, Vol 32. No.12, pp 1701-1716.

Cornelissen, J.P., Clarke, J. and Cienki, A. (2012), Sensegiving in entrepreneurial contexts: The use of metaphors in speech and gesture to gain and sustain support for novel business ventures, *International Small Business Journal*, Vol. 30 No. 3, pp. 213–241.

Currie, G. and Brown, A.D. (2003), A Narratological Approach to Understanding Processes of Organizing in a UK Hospital, *Human Relations*, Vol. 56 No. 5, pp. 563-586.

Currie, G. and Lockett, A. (2011), Distributing Leadership in Health and Social Care: Concertive, Conjoint or Collective?', *International Journal of Management Reviews*, Vol. 13, pp.286-300.

Currie, G. Koteyko, N. and Nerlich, B. (2009), The dynamics of professions and the development of new roles in public services organisations: the case of modern matrons in the English NHS, *Public Administration*, Vol. 87, pp. 295–311.

Dickinson, H. (2011), 'Implementing policy'. In Glasby, J. (ed) *Evidence, policy and practice: critical perspectives in health and social care.* Bristol: Policy Press, pp 71-84

Dickinson, H. Millar, R. and West, M. (eds) (2011), 'Mind the gap: policy and practice in healthcare reform', *Journal of Health Organization and Management*, Vol. 25 No.3, pp. 244-246

Dickinson, H and Mannion, R (2012) (eds), *The Reform of Healthcare: Shaping, Adapting and Resisting Policy Developments*, Palgrave MacMillan: Basingstoke.

Dickinson, H. (2014) *Performing Governance Partnerships, Culture and New Labour*, Palgrave MacMillan: Basingstoke.

Down, S. and Warren, L. (2008), Constructing narratives of enterprise: Clichés and entrepreneurial self-identity, *International Journal of Entrepreneurial Behaviour and Research*, Vol. 14 No.1, pp. 4–23.

Elkind, A. (1997), Using metaphor to read the organisation of the NHS, *Social Science & Medicine,* Vol. 47, No.11: 1715-1727.

Fairhurst, G.T. (2009), Considering context in discursive leadership research, *Human Relations*, Vol. 62 No.11, pp. 1-27.

Ford, J. D., L. W. Ford and A. D'Amelio (2008), Resistance to change: the rest of the story, *Academy of Management Review*, Vol 33, pp. 362–377.

Ford. J. Harding, N. and Learmonth, M. (2008), *Leadership as identity: constructions and deconstructions*. Palgrave Macmillan: Basingstoke.

Gergen, K. J., M. Gergen, F. J. Barrett. (2004), 'Dialogue: Life and death of the organization'. In D. Grant, C. Hardy, C. Oswick, L. Putnam, (eds.) *Handbook of Organizational Discourse*. Sage, London, 39–60.

Gioia, D.A. and Chittipeddi, K. (1991), Sensemaking and sensegiving in strategic change initiation, *Strategic Management Journal* , Vol 12, pp. 433–459.

Gioia, D.A. Thomas, J.B. Clark, S.M. and Chittipeddi, K. (1994), Symbolism and strategic change in academia: The dynamics of sensemaking and influence, *Organisation Science*, Vol 5, pp. 363–383.

Goodwin N, Smith JA, Davies A, Perry C, Rosen R, Dixon A, et al. (2012) *A report to the Department of Health and NHS Future Forum: integrated care for patients and populations: improving outcomes by working together*. King's Fund, Nuffield Trust, London.

Grant, D., and Oswick, C. (1996) Metaphor and organisations. London: Sage.

Greener, I. Harrington, B. Hunter, D. Mannion, R. and Powell, M. (2014), *Reforming healthcare: What's the evidence?*, Bristol: Policy Press.

Hardy, C., T. Lawrence, D. Grant. (2005) Discourse and collaboration: The role of conversations and collective identity, Academy *Management Review*, Vol. 30 No.1, pp. 1–20.

Hill, R. and Levenhagen, M. (1995) Metaphors and mental models: Sensemaking and sensegiving in innovative and entrepreneurial activities. *Journal of Management,* Vol. 21 No.6, pp: 1057–1074.

Hudak, P. L. McKeever, P. and Wright, J.G. (2003) The metaphor of patients as customers: Implications for measuring satisfaction, *Journal of Clinical Epidemiology*, 56, pp. 103–108

Hurwitz, B. Greenhalgh, T. and Skultans, V. (2008), *Narrative Research in Health and Illness*, BMJ, Blackwell: Oxford.

Lakoff, G. (1993), The contemporary theory of metaphor. In: Ortony A. (ed.) *Metaphor and Thought*, 2nd edn. Cambridge: Cambridge University Press, 202–250.

Lakoff, G. and Johnson, M. (1980) *Metaphors We Live By*. Chicago, IL: University of Chicago Press.

Laranjeira, C. (2013), The role of narrative and metaphor in the cancer life story: a theoretical analysis, *Medical Health Care and Philosophy*, Vol. 16, pp. 469–481

Mays, N. Dixon, A. and Jones, L. (eds) (2011), *Understanding New Labour's Market Reforms of the English NHS*, London: King's Fund.

Malone, R.E. (1999) Policy as Product: Morality and Metaphor in Health Policy Discourse, *The Hastings Center Report*, Vol. 29 No. 3, pp. 16-22

McDermott, A. M. Fitzgerald, L. Buchanan, D. (2013), Beyond Acceptance and Resistance:

Entrepreneurial Change Agency Responses in Policy Implementation, *British Journal of Management*, Vol. 24, S93–S115

McFarland, L. Barlow, J. Turner, A. (2009), Understanding metaphor to facilitate emotional expression during a chronic disease self-management course, *Patient Education and Counselling*, 77, pp. 255–259

McLeod, H. Millar, R. Goodwin, N. and Powell, M. (2014), Perspectives on the policy 'black box': a comparative case study of orthopaedic services in England, *Health Economics, Policy and Law*, EarlyCite DOI: 10.1017/S1744133114000048

Millar, R. (2009) *The construction and use of NHS Modernisation Agency Improvement Leaders' Guides in healthcare delivery*, PhD, University of Manchester.

Millar, R. Mulla, A. and Powell, M. (2013) Delivering reform in English healthcare: an ideational perspective, *Public Policy and Administration*, Vol. 28 No.3, pp.233-252.

Morgan, G. (1980), Paradigms, metaphors and puzzle solving in organisational theory, *Administrative Science Quarterly*, Vol 25, pp. 605–622.

Morgan, G. (2006) *Images of Organisation*: Updated Edition. Sage, London.

Needham, C. (2011), Personalization: From Story-line to Practice, *Social Policy &*
Administration, Vol. 45 No. 1, pp. 54-68.

Newman, J. and Vidler, E. (2006), Discriminating Customers, Responsible Patients, Empowered
Users: Consumerism and the Modernisation of Health Care, *Journal of Social Policy*, Vol. 35
No. 2, pp. 193-209.

O'Reilly, D. and Reed, M. (2011), The Grit in the Oyster: Professionalism, Managerialism and
Leaderism as Discourses of UK Public Services Modernization, *Organisation Studies*, Vol. 32,
No.8, pp.1079-1101.

Penson, R.T. Schpira, L. Daniels, K.J. Chabner, B.A. and Lynch JR, T.R. (2004) Cancer as
Metaphor, *The Oncologist*, Vol 9, pp.708-716.

Pragglejaz Group (2007) MIP: A method for identifying metaphorically used words in discourse.
Metaphor and Symbol, Vol 22 No.1, pp. 1–39.

Putnam, L. L., and Boys, S. (2006) 'Revisiting metaphors of organisational communication'. In
The Sage handbook of organisation studies. S. R. Clegg, C. Hardy, T. B. Lawrence and W. R.
Nord (eds),: 541–576. London: Sage.

Robert, G. and Fulop, N. (2014) *Perspectives on context: The role of context in successful*
improvement, Health Foundation: London.

Schlesinger, M. and Lau, R.R. (2000), The Meaning and Measure of Policy Metaphors, *The American Political Science Review*, Vol. 94, No. 3, pp. 611-626.

Sontag, S. (1978), *Illness as Metaphor*. New York: Farrar, Straus and Giroux.

Steen, G. (1999) From linguistic to conceptual metaphor in five steps. In *Metaphor in cognitive linguistics*. R. W. Gibbs and G. Steen (eds), 55–77. Philadelphia: John Benjamins

Thomas, R., L. D. Sargent and C. Hardy (2011), Managing organizational change: negotiating meaning and power– resistance relations, *Organization Science*, Vol 22, pp. 22–41.

Tsoukas, H. (1991), The missing link: A transformational view of metaphors in organisational science, *Academy of Management Review,* Vol 16, pp. 566–585.

Tsoukas, H. 2005. Afterword: Why language matters in the analysis of organizational change. *Journal of Change Management*, Vol 18 No 1, pp. 96–104.

Tsoukas, H., R. Chia. (2002) On organizational becoming: Rethinking organizational change. *Organisation Science*, Vol. 13 No.5, pp. 567–582.

Weick, K. E. (1995) *Sensemaking in Organizations*. Sage, Thousand Oaks, CA.

Weick, K.E. Sutcliff, K.M. and Obsfeld, D. (2005), Organizing and the process of sensemaking, *Organization Science*, Vol 16 No.4, pp. 409–421.