

Getting to the very heart of the matter

In the folklore of the Middle East, the story is told about a man named Nasrudin, who was searching for something on the ground. A friend came by and asked 'What have you lost, Nasrudin?'

'My key,' said Nasrudin.

So the friend went down on his knees, too, and they both looked for it. After a time, the friend asked: 'Where exactly did you drop it?'

'In my house,' answered Nasrudin.

'Then why are you looking here, Nasrudin?'

'There is more light here than inside my own house', replied Nasrudin.¹

The only thing I know about Sufism is that it is based on the teachings of a pantheistic Mohammedan mystic and that it has a seemingly endless raft of stories to illustrate particular principles. Not exactly an encyclopaedic knowledge on my part, I admit, but the above story is a perfect metaphor for what I want to say about getting to the very heart of the matter.

Please spend a minute or two thinking about the story of Nasrudin. Picture the story in your mind and see if you can move your thinking from a position where you might have reacted initially by saying 'What a stupid thing to do!' to a position where you might say to yourself 'What a profound story'. It is easy to dismiss Nasrudin as foolish: 'Can you imagine losing something in your house and then spending your time looking for it outside the house? Not even a relaxing 20 minutes in the sun would make me do that.' Think for a moment. Are there times when you do exactly the same thing? Not with a house key you may have misplaced, but perhaps with aspects of your everyday work. Are there things in your healthcare setting that have been lost – not so much a key or a computer disk, but something significant such as the loyalty of your staff or the performance of your department – and instead of looking in the place where it was probably lost you start looking *outside the house*? There is 'more light' there, or perhaps it is just that it is more comfortable, as it avoids the need to ask some very important and searching questions.

At this point, those who have read the previous paragraph and given it some

thought are likely to fall into two camps. The first are those who are beginning to connect with the point I am making, or may even be ahead of me. The second camp are thinking to themselves, 'What on earth is he getting at?' If you fall into the second camp, please read the story of Nasrudin again and think about your own healthcare work. If you still cannot make head or tail of what I am suggesting, please stay with this chapter a little longer, in the hope that all may become clear before too long. If it really is proving quite impossible to remain with this line of thought, please go to the next chapter where there will be no more of this 'touchy-feely' stuff. For those of you who are still with me – thank you, and let us think more about people in our healthcare organisations who might resemble Nasrudin in the way in which they behave.

DEALING WITH PROBLEM ISSUES

Many people see a problem in their healthcare organisation – it may well be to do with performance, or patient care, or the morale of their staff – and the temptation to do something, something tangible, is almost overwhelming:

There is a problem in my department and I am the one in charge, so I've got to do something about it. Action. Clear action. I must show that I am doing something about the problem. I can't leave this problem to fester. It will get worse and then it will be even harder to solve. What can I do? I must be proactive. I must show I am managing the problem.

And without too much time for reflection, they plunge into management action. It may not solve the problem, but at least they can be seen to be doing something about it.

In these organisations, and at most levels of management, action in response to the problem is put in place, and of course something will begin to happen. The action might not be undertaken as a result of a careful analysis of the underlying causes of the problem – an evidence-based approach, to use the jargon – as there has been no time for such an approach, and to commission evidence gathering might give the appearance to others (especially one's boss) of dithering, of not knowing what to do, of indecision. Such problems call for management action, not evidence gathering! The fact that the all-action managers once read a management theorist who showed that 'today's problems come from yesterday's solutions'² or who warned of the dangers of 'symptomatic solutions to systemic problems' is immaterial – it seemed to make sense then and squared with their experience of managerial life, but now it is different. Something has to be done. And so, like Nasrudin in the story above, the managers embark on their course of action. They are operating where they believe there is plenty of light. It might not be where they lost the precious article – the team's performance, or patient care or staff morale – but this is where they think they are likely to find the answer. This is where 'their light' is, or so they think, and this is where they can show best of all that they are taking action.

From my experience, if the challenge being addressed is a major issue then it is likely that this rush into action will take one or more of three forms:

- 1 there will be a reorganisation of the way things are done, and this will probably involve some form of restructuring of the healthcare organisation *and/or*
- 2 it will lead to the introduction of some new concept into the organisation based on the latest thinking of some management guru *and/or*
- 3 there will be a new policy or strategy, described as part of a strategic management response, to meet the need that has arisen in the organisation.

DEALING WITH CAUSES: THE REAL ISSUES

Before I deal with each of these points in turn, I must deal with the hint of cynicism that has found its way into my comments. These three approaches are true of all types of organisation, and should not be seen as peculiar to the health sector. Nor should the three points be interpreted as a criticism of the health service – I am one of its greatest supporters. Also, I am not opposed to reorganising or restructuring an organisation. There are times when it is absolutely essential and the ‘proof of the pudding’ is the success resulting from such action. Nor am I against some of the new concepts – what critics may call the latest fads – which have been introduced into management, especially over the last 20 years. I have used most of them and believe that they have a major role to play in most healthcare organisations. Nor am I against the introduction of new policies and strategies. How could I be when I have introduced such policies myself, when I have seen strategies reap rich rewards for a healthcare organisation, and when world-class experts (theorists and practitioners) have written so influentially on the subject? My objection concerns those times when the three responses (reorganisation, new concepts and new strategies) are used in a similar way to Nasrudin looking for his key. Too many people confuse relentless, breathtaking activity with meaningful action that tackles the genuine underlying issues within the organisation. In other words, there is an abundance of proactive action, but it is action that does not necessarily address the fundamental issues in the healthcare organisation. The action is dealing with the symptoms of the problem but is not getting to the underlying causes, to the root of the problem – it is not ‘getting to the very heart of the matter’.

Systems thinkers – those people who understand that organisations are complex interrelated entities and that isolated initiatives can do more harm than good – appreciate the dangers inherent in dealing with the symptoms of a problem rather than with the underlying reasons that caused it in the first place. Most leaders of healthcare organisations have learned the importance of systems thinking – looking for underlying trends and forces for change – as they are only too aware that:

The pressures to intervene in management systems that are going awry can be overwhelming. Unfortunately, given the linear thinking that predominates in most organisations, interventions usually focus on symptomatic fixes, not underlying causes. This results in only temporary relief, and it tends to create still more pressures later on for further, low-leverage intervention.³

THE TEMPTATION OF CHANGING ORGANISATIONAL STRUCTURES

Anyone who has travelled around offices in different organisations, not only healthcare ones, will almost certainly have seen a quotation by someone called Petronius Arbiter (*c.* AD 60), pinned to the office noticeboard:

I came to learn later in life that we tend to meet any new situation by reorganising; and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralisation.

Petronius Arbiter lived under the reign of Nero and is mentioned by writers such as Pliny the Elder and Tacitus, although it is not always entirely clear whether he was the author of all the sayings attributed to him. What is clear is that he appears to be one of the most quoted members of the school of ancient organisational philosophers. Even though no such school existed, the retrospective collection of quotes such as these, from a range of Greek philosophers, gives the impression that Athens had a thriving business school long before the birth of Christ!

The Petronius Arbiter poster reveals that these employees, in what appears to be an act of defiance and yet at the same time an act of resigned acquiescence to the latest in a line of reorganisation proposals, find considerable solace in his words. The words might even serve as a source of finger pointing at those senior managers who change organisational structures far too often and without the support of the workforce. As far as the employees are concerned, the organisation's senior management are restructuring for the umpteenth time and yet again, as happened the last time and every previous reorganisation before that, great benefits for the provision of healthcare and its staff are being promised. The proposals claim major cost savings, improvements to the way in which the organisation deals with its patients, and general improvements in the way in which everyday activity is conducted.

The suggestion made by management is that everything will be noticeably better, but the person who placed the Petronius Arbiter quotation on the noticeboard sees things differently. There will be changes. The organisation may be centred around patient services rather than geographical territories; certain new ideas or strategies may be introduced; one or two faces may even appear, but despite these changes eventually, as night follows day, life will go on much the same as before. Those driving through the organisational change programme may interpret such attitudes as unjustifiable cynicism, but those who have experienced the various ways in which the organisation has been organised previously will regard their view as no more than realism based on experience of life in their hospital. At the very least, the reaction of the staff, captured in the Petronius poster, shows that those charged with bringing about change have failed to spend enough time convincing their employees of the genuine need for change. If only these organisations had paid heed to the words of Robert Townsend: 'Reorganisation should be undergone about as often as major surgery. And should be as well planned and as swiftly executed.'⁴ If only they had made sure that the proposed changes had been based on hard evidence, that staff had been convinced of the need for change, that the changes would deal

with fundamental underlying issues, and that the ideas and genuine concerns of staff had been dealt with in a meaningful way.

ORGANISATIONAL TYPES

Whether or not organisations reorganise, and whether or not the changes are seen as justifiable by the staff, it never fails to surprise me how little imagination some managers put into the type of structures that most organisations introduce. Anyone examining the typical organisation chart will find an all too familiar sight – so many of them follow what is known as the traditional and bureaucratic hierarchical model. In this model (*see* Figure 8.1) one manager oversees the work of four or five others who in turn manage the work of five or six others. The chart has been drawn by someone with the precision of an architect, and unsurprisingly it has a balanced, symmetrical feel to it. There is a sense that this is an organisation that functions extremely efficiently, and that its groups look after departments, and its departments look after units. It is regimented, even militaristic in its appearance, and gives the impression that every activity within the organisation follows a set of formal processes and systems. In the first organisation I worked in I recall being told that as a member of a particular division, especially as I was a humble management trainee, I could only enter into formal communication with a member of another division by following a set of arcane procedures. This involved proceeding up the management hierarchy, with a paper setting out my position, thereby allowing the head of my division to communicate with individuals employed in the other division by means of a memorandum. Thankfully those days have long gone, but the vestiges of them remain in far too many places.

Organisational theorists have a lot to answer for! Even today I am surprised by the number of standard textbooks on organisational theory in which little understanding appears to exist about the variety of potential organisational forms. Most texts introduce the student, even if they are a senior manager, to three basic organisational forms.

There is the traditional hierarchical model, sometimes known as the functional organisation (*see* Figure 8.1).

Then there is the version based on the particular service or ‘product’ (*see* Figure 8.2) or, just as easily, on a geographical territory.

The concept of the matrix organisation (*see* Figure 8.3) is introduced and the student is made to feel that they are in the presence of leading-edge thinking.

Thankfully, most organisational theorists (and this includes the vast majority of business schools) introduce students and executives to a much wider range of organisational models. The work of Henry Mintzberg, for example, shows the availability of key differences in organisational design ‘appropriate to deal with different sets of contingency factors, reflecting variation in the organisation’s age, size, technical system and environment’.⁵ Mintzberg introduces five types of organisational model, namely the simple structure, machine bureaucracy, professional bureaucracy, the divisionalised and the adhocracy. As you will have gathered by now, my intention in writing this book is not to summarise the content of various textbooks by an array of academics. Their works are

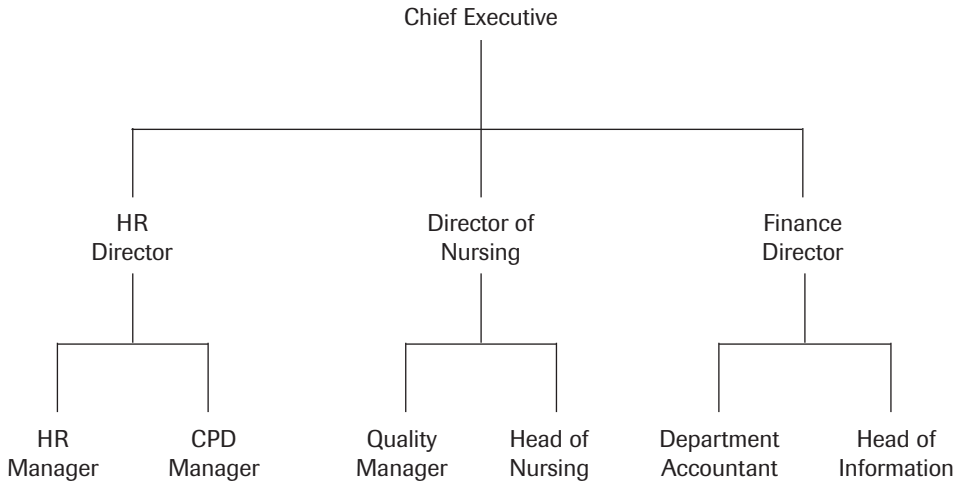


FIGURE 8.1 Traditional hierarchical model

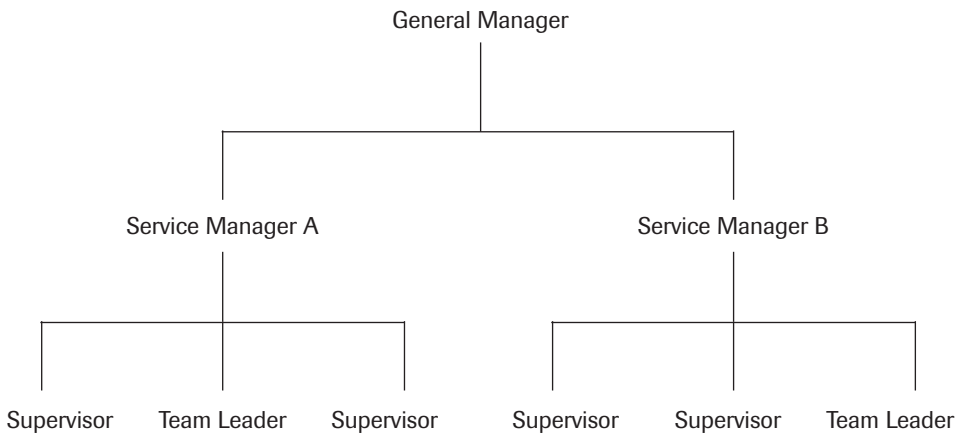


FIGURE 8.2 Typical example of product organisation

accessible and any brief précis of them would be a grave injustice. It is sufficient to refer to Mintzberg’s work and to show that various forms of organisations exist and that they are sensitive to the needs of various settings. The experienced healthcare reader will understand this and appreciate that there are far more models available than the traditional hierarchical models so admired in many organisations.

Charles Handy makes a similar point to Mintzberg in his classic work *Gods of Management*.⁶ In his inimitable style he uses four gods from Greek mythology to introduce four very different types of organisation (see Figure 8.4).

Apollo is the formal role culture much used by traditional organisations.

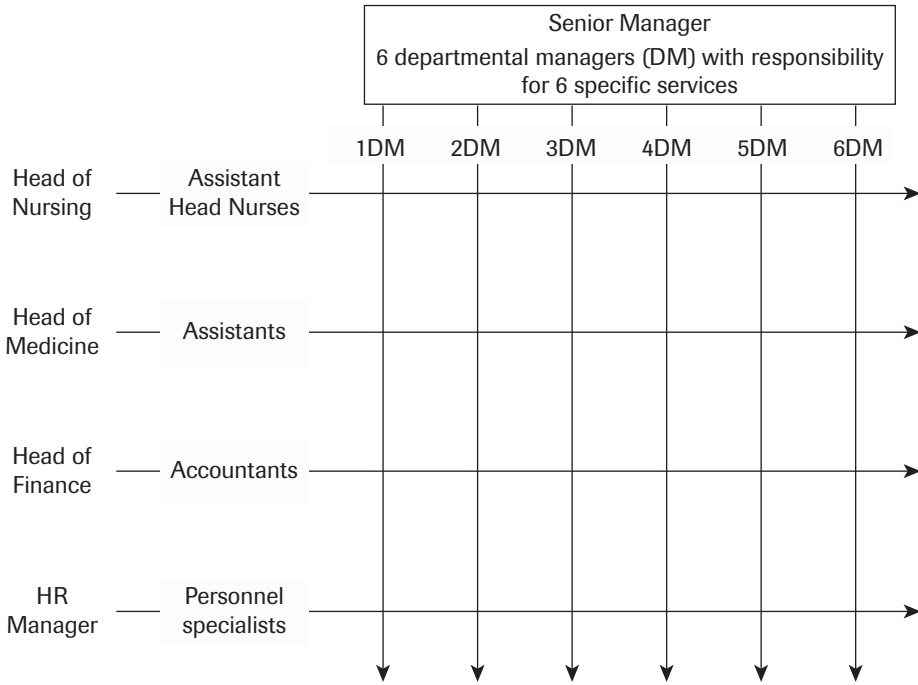


FIGURE 8.3 Typical example of matrix organisation

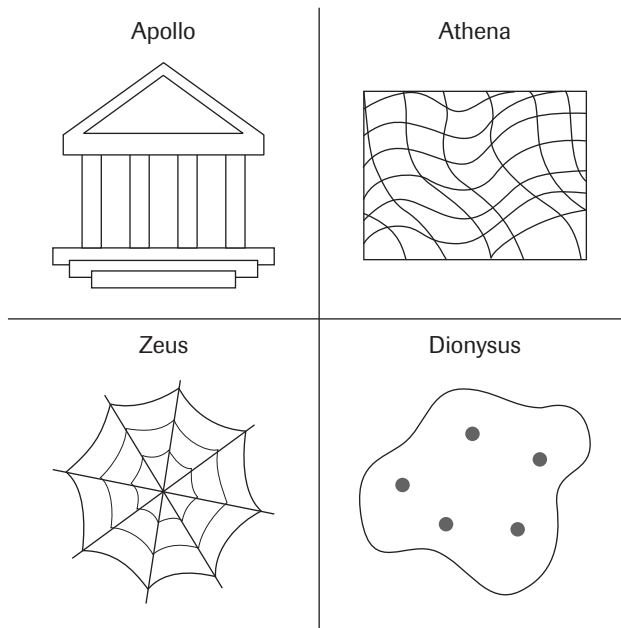


FIGURE 8.4 Charles Handy's 'Gods of Management'
 Source: Handy C (1995) *Gods of Management: the changing work of organisations*. Arrow, London.

Work is based around the role and the job to be done, rather than around individuals and the skills and knowledge that they bring to the workplace. *Athena*, on the other hand, is the task culture. With *Athena*, the solution of problems is the key factor and people are continually drawn into task and project teams. This is matrix management 'gone mad', and is typical of many of the organisations that have been springing up in the 'new economy' of the 1990s and the early part of the twenty-first century. *Zeus* represents the club culture in which all activity derives from and exists around the presence of the 'spider' in the middle of the web. This model is typical of small entrepreneurial entities where contact with the founder – the organisation's inspiring force – is a critical issue. However, anyone who has worked in such an organisation will also know that such a powerful character at the centre of these empires has a magnetic influence on others and is crossed at some peril. Finally, there is *Dionysus* and the existential culture. This organisation is a typical home for barristers, architects and similar professionals. Those who belong to an organisation of this type usually do so grudgingly and only for the benefits that it brings them.

Gareth Morgan⁷ takes the design of organisations to a new level and uses metaphors, including the organisation as a machine or as an organism, to help to illustrate the different organisational models. My favourite part of his work, and the one I refer to with clients and colleagues, is his use of a spider plant to show that it is possible to 'grow large whilst remaining small'. The spider plant has the ability to send out shoots that create the image of the 'parent' plant and remain connected to it by the equivalent of an umbilical cord.

He shows that the notion of franchising in retailing can be applied in other contexts, such as large healthcare organisations, and that it is possible to increase the size of an organisation without gargantuan growth in the size of the head office and the bureaucratic procedures that follow. In his version, the organisation must have a clear set of values and operating principles, and 'successful decentralisation depends on the development of good "umbilical cords"'. When I explain this concept to clients they find it an appealing idea but few have the time, or perhaps the courage, to make it a reality in their work environment. It is extremely risky to run a healthcare organisation predominantly on the basis of values, and the production of formalised sets of rules and regulations is a much safer and easier option.

THEORY VS. PRACTICE

During a visit to a healthcare organisation it is a source of fun to compare the formal organisation chart with how things are actually run, as they are rarely the same. Although the organisation chart purports to reflect the organisational arrangements within the healthcare setting, it seldom captures the variety of fluctuations and nuances. If only organisation charts were drawn accurately – they would show the most complicated set of relationships and interrelationships, far too messy for the bureaucratic need to have a piece of paper that suggests order and control.

One organisation that I consulted with regularly, and another in healthcare that I used to run, recognised and celebrated the fact that they had all four of

Charles Handy's 'gods' happily co-existing within their overall structures. Both of these organisations, to ensure that the performance and accountability requirements of their parent body were met, often operated in formal Apollo-mode. To ensure that most of its projects were delivered, the organisation had created a system of teams very similar to Athena-mode. Some of its key clients were Zeus-like in their behaviour, and so the organisation had to respond in that particular style, and some of their own staff, those with an element of prima-donna temperament, worked in a way that would be at home in the Dionysus culture. These two organisations recognised these four styles as a fact of life, and saw them as a virtue rather than a vice, and their acceptance of these different styles has avoided any sense of there being organisational schizophrenia. Although they had a formal organisational chart to satisfy their Apollo-like parent body, their actual chart, if it were ever drawn, would contain the most amazing set of zigzagging lines and unusual relational shapes. When a formal body visited them, they were able to produce an organisation chart showing traditional, hierarchical lines and a well-ordered organisation, but they also adopted variations on that structure on a day-to-day basis. They were thriving organisations because they made a virtue out of their diversity and allowed their staff creative freedom and the ability to respond to the needs of the organisation and its users.

NEW CONCEPTS AND NEW STRATEGIES

Two of the best recent autobiographical management books give dramatic accounts of how Jack Welch⁸ transformed General Electric and how Louis Gerstner⁹ rescued the commercial reputation of IBM. They are stirring tales, modern classics of managerial adventure. They also offer a detailed insight into the value of introducing appropriate new approaches into an organisation, and of the importance of revising existing strategies and introducing new ones. Without the efforts of Welch, Gerstner and their teams, plus the application of their strategies, it is possible that General Electric and IBM would not be what they are today, and might even have gone to the wall.

My reason for highlighting the sterling efforts of Welch and Gerstner is to make it perfectly clear once again that I am not opposed to new initiatives and strategies aimed at tackling old and new problems. In fact, I am a keen advocate of the majority of new initiatives, and perhaps there were times in my managerial career when I was too great an advocate of new approaches, and a poor reader of the organisational politics as to whether something should be introduced or the best time to introduce it. I have sponsored quality management programmes in healthcare and remain convinced that two of the quality maxims, 'fit for purpose' and 'conformance to standards', have stood the test of time and still have much to offer any healthcare organisation, and indeed the economy at large. I have also welcomed the development of the European Foundation for Quality Management and the work known as Sigma. Benchmarking and business process re-engineering were a joy to sponsor in healthcare. In addition, comparing oneself with leaders in the field and streamlining the way in which management is undertaken in the interest of one's patients or clients made

absolute sense then and always will do. I could make similar comments about many other initiatives. The same is true of strategy. I am a firm believer in the importance of developing strategy within an organisation and I realise that, from the perspective of both theory and practice, without strategy most ideas will remain a mere pipedream.

It is not the managers who subscribe to new approaches and new strategies that alarm me, but rather it is those who subscribe to one of the new approaches without having any intention of working with it in a substantial and systematic manner. They are far more interested in being associated with the latest managerial gizmo than with doing something that, over time, will really improve their organisation and its performance. They talk about it, they use all the right jargon, and if there is a chance of putting some symbol on their letterheads that shows their commitment to it, then they are the first in the queue. However, doing something with it, something that will fundamentally alter their organisation, is quite another thing. They are the 'here today, gone tomorrow' brigade. By the time they should be evaluating their last strategy they are far too busy worrying about their next initiative, which will supposedly transform the entire organisation.

MERE MOOSE HEADS!

Gareth Morgan's moose-head cartoon¹⁰ is profound and sums up the approach of the managers I have been describing. In the cartoon he shows a collection of moose heads affixed to a plinth on the boardroom wall, with a number of management initiatives listed below. Each moose head represents an initiative, a programme that has been successfully adopted (although probably not implemented systematically). Quality? Leadership? Re-engineering? Equal opportunities? 'Been there, done that, got the T-shirt', to quote the once popular UK television advert, is their tacit and even outspoken response. They collect these approaches like a child collecting computer games, they sign up for a variety of fanciful initiatives, they drive their staff crazy with yet another new programme, and once they have obtained their 'moose head' they put it on the boardroom plinth and smile at it admiringly once a month. What is worse, they have managed to make their key employees disaffected with any such initiative, and they themselves have become inoculated against the full effect of the initiative's impact. They have experienced a little of its effect, just enough to immunise them against its full effect, and then they move on to look for the next short-term miracle cure for their organisational problems.

Successful healthcare and other organisations that have survived a range of challenging conditions over a long period of time appear to do the very opposite of the quick-fix, short-term approach. In general they choose a new initiative carefully, they try not to make too much of a song and dance about it, they often do not give it a specific title, and they attempt to integrate it into their traditional approach to the management of the organisation. Most importantly, they stick to the chosen approach and work hard to make it a success. They realise that there are few quick-fix solutions to be had, and that most things have to be worked at over a long time. Therefore, the new initiative has more chance of

being successful, and if it fails then it will quietly wither away without creating the antagonism that brasher approaches seem to generate.

INTEGRATING INITIATIVES AND STRATEGIES

In the early 1990s, one healthcare organisation (which is now a successful and well-thought-of NHS trust) asked me to work with them on their SIMT programme. When I asked for the acrostic to be explained, they told me that it stood for the *Simultaneous Implementation of Management Techniques!* They intended to roll various new initiatives, such as quality management, benchmarking, re-engineering and much more, into one integrated initiative and then absorb it into everyday management practice. We spent time thinking about it, we examined the common themes of each of the separate programmes and brought together the features of the separate initiatives into one programme – a single SIMT. The theory was impeccable, we had produced the ‘simultaneous implementation of management techniques’, but in practice the implementation was far more difficult as the already committed front-line managers thought the chief executive had ‘bitten off more than they (rather than he) could chew’ in one go. I salute them for their efforts, and when I visited them some months and then years later, it was encouraging to see the progress that they had made. In their understated yet comprehensive and methodical way they had achieved much and continued to be one of the leading NHS trusts. They were outwardly rather unassuming, yet they got on with the job and made real progress. There is clear evidence that their continuing progress is due in large part to the mature and sophisticated way in which they tackled and absorbed new opportunities.

Strategy is a similar issue. Everyone accepts that new policies and strategies are essential to a healthcare organisation and its development. However, there are times when the cavalier way in which some managers develop, use and seemingly abuse them makes one wonder whether they really understand this principle at all.

Consider the example of what I call the ‘jam tomorrow’ user of strategy. They see strategies as an opportunity to promise major transformations in the performance of their department or profession . . . in the near future. With them, things will always be better in the near future – hence the term ‘jam tomorrow’ – and they operate on the basis that by the time the promised ‘tomorrow’ arrives either they will have moved on to a new post, or the circumstances in which they are working will have changed to such an extent that they will not be held to account for their original strategy. Watching the ‘jam tomorrow’ brigade operate is almost like being the spectator of some new sport or art form. They are masters at putting off the day on which they have to deliver, and in the meantime they create immense activity (project groups, working parties and implementation plans) that attract large groups of supporters who genuinely believe that they are involved in critically important work.

Then there are those whose approach to policy and strategy appears to be driven by a touch of megalomania and egomania. For them, strategy formulation resembles something close to world domination for their service, and their forecasts for performance can even enter the realm of make-believe. I have seen

this approach in many major organisations, but two examples will suffice here. One of the examples is a large manufacturing conglomeration, and the other is an international institution involved in developing health policy. Their claims beggared belief – one was going to swamp the world with its product and the other was going to achieve a radical transformation in the lives of countless millions. They seemed to be oblivious to the ‘weaknesses’ and ‘threats’ (to take the ‘W’ and ‘T’ out of SWOT analysis) of their strategic plans, and regarded any counter-argument as pessimistic and negative thinking and not in keeping with the positive outlook associated with the *raison d’être* of their organisation. Anyone who attempted to point out that the Emperor did not have any clothes was immediately labelled ‘not one of us’ and risked becoming an organisational outcast. Needless to say, both strategies came to grief, but one of the organisations managed to explain it away, in a similar manner to the ‘jam tomorrow’ practitioner, by explaining that the environment in which they were operating had changed dramatically and they could not have anticipated those changes under any circumstances. The other organisation teetered on the edge of bankruptcy and is now mainly famous for the extent of its downsizing programme, rather than for its products.

CONCLUSION

Remember Nasrudin? He spent his time and effort looking for his key in places where there was more light, and where people could see his industry, but where his chances of succeeding in his mission were zero.

His story should serve as a parable for managers everywhere and a challenge to check whether new strategies, or departmental reorganisations, or the introduction of new approaches, are an act ‘in the light’ rather than one that addresses the fundamental issues that they are facing. They need to ask themselves, and to ask themselves honestly, where and how their organisation and its people lost their ‘key’. This is the only way in which effective change can become a reality.

The problem often lies with the core beliefs and behaviours of their team. Every time I visit the USA I am impressed by their positive attitude to customer service. When I am in France, I am astonished by their veneration for food and wine and the entire eating experience. But have you been to Paris Disneyland and seen the reluctance with which they attempt to adopt the ‘have a nice day’ American-based culture of Disney? It should be a clear lesson to all of us – instructing a workforce to utter some well-chosen words is not the same as bringing about a fundamental cultural change. We accept that fact, yet there are managers who will act as if, with a little reorganisation, some superficially applied new concept, and the announcement of a new policy or strategy – hey presto, all will be well in my organisation . . . but probably next year or the year after.

There are times in healthcare organisations when the issues that need to be tackled concern fundamental core beliefs and behaviours, yet the ever-optimistic manager, driven by the need to be seen to be taking proactive action, decides to reorganise the department. This is a manager of action, but action that will most likely prove to be futile in a short while. The tragedy is that these

managers – albeit a minority – genuinely believe that reordering some posts on an organisational chart will fundamentally change the behaviour of their people. How sad this is.

They are working in the light instead of looking in the house.

Key actions

- 1 Try not to fall into the trap of treating only the symptoms of a problem. It really is important to identify and deal with the underlying causes.
- 2 Please think long and hard about the parable of Nasrudin and then answer this question honestly: 'Do I ever look outside the house and, if so, why do I do it?'
- 3 Here is another question: 'When you introduce a new strategy or initiative do you see it through or are you a gatherer of "moose heads"?''

REFERENCES

- 1 Mintzberg H (1989) *Mintzberg on Management*. The Free Press, New York.
- 2 Senge PM (1990) *The Fifth Discipline: the art and practice of the learning organization*. Century Business, London.
- 3 Senge PM (1990) The leader's new work: building learning organizations. *Sloan Manag Rev.* 32(1): 7–22.
- 4 Townsend R (1971) *Up the Organisation*. Coronet, Philadelphia, PA.
- 5 Mintzberg H (1979) *The Structuring of Organisations*. Prentice Hall, Englewood Cliffs, NJ.
- 6 Handy C (1995) *Gods of Management: the changing work of organisations*. Arrow, London.
- 7 Morgan G (1998) *Images of Organisation: the executive edition*. Berrett-Koehler, San Francisco and Sage, Thousand Oaks, CA.
- 8 Welch J and Byrne JA (2001) *Jack*. Headline, London.
- 9 Gerstner LV (2002) *Who Says Elephants Can't Dance?* HarperCollins, London.
- 10 Morgan G (1993) *Imaginization: the art of creative management*. Sage, London.