Hospital marketing, potential space and transitional objects in the transformation of Dutch health care.

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transformation

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symmetric and asymmetric organisation of experience

transformation and group relations

the object of marketing

relations and relatedness

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0. Introduction

In this presentation hospital marketing - in the situation of recent changes in government regulation of the Dutch health care sector (from public to – more – private sector services) is discussed, reflecting on practical work using different theories of transformation that are psychoanalytic oriented.

In the Netherlands marketing or being 'market oriented' has become synonymous with the transformation that managers in (health) care are looking for and held accountable for. It is implied that healthcare / hospitals are not demand driven and therefore should change. Marketing is supposed to identify this problem and show how to work differently in and with 'the market'. At the same time marketing is seen as the way to take an economic stance towards relationships with patients, in order to 'economize' relationships with patients.

"My people are used to changes that are slow. It worries me that the pace has gone up so much that it seems to me that our organisation has no more time to slowly adjust but instead has to take initiative itself." This is a quote of a director of a care institution whom I spoke recently. And it resonates with the views of many managers in (health) care institutions.

How does a hospital / care organisation (professionals and doctors) respond to all the changes in the regulations? The situation in the health / care sector is experienced as 'a new world' as a director that I know calls it. Even doctors have to be entrepreneurial. He tells me he sees it as transformation.

It is in this context of transformation that I am looking at marketing. Transformation is a concept that is used in many ways and over the last years has become a buzz word in management and consultancy. In this presentation I will try to understand better what transformation means in everyday organisational life in (health) care in the Netherlands. For some time now management is a growing capacity / profession in these institutions. And management knowledge and tools are introduced and used on a ever larger scale. Marketing management and its images, concepts and instruments is the latest 'add on'. It can be dismissed or it can be looked at in a more pragmatic way.

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After having introduced the topic of the transformation of the Dutch Health care on a national level, I go on to give some background on a case of 'marketing' in a hospital / elderly care home, where a need for marketing was expressed and were I did management and OD work. This is the first part. In the second part I reflect on this using theories of transformation and connect them with data from the case. In the third part I look on marketing again with the question 'What I think the object of marketing is?'

I was interested in doing the work for this presentation as a reflection on practical work. I have done some work and now I am presenting that to you. I am sure you will respond in a way in which the learning continues.

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Part 1.

Changing regulations and client need

Over the last few decades, several governments have proposed changes to the (health) care system in the Netherlands. Suddenly, within the term of the last government, these changes have 'materialized'. Since the beginning of 2006, on the basis of a new law, government policies and regulations have changed with an impact on the whole sector and its stakeholders.. At the same time these changes are not fully implemented, but are projected to be implemented between now and 2012, when hospitals (and other care organisations) are thought to have a choice to operate as profit making organisations.

In the public debate about the future of (health) care over the last years a sense of urgency has been introduced by politicians. Government itself has declared that its regulating role should be different, since citizens are considered to be self steering and responsible consumers. At the same time scenario's are presented suggesting that health care in the future is going to become too expensive for society to collectively finance. Therefore insurance companies are forced into having a role in steering costs and efficiency. The public (through representing bodies) supports the belief that reform can no longer be waited for. This is voiced as a need for transparency in the way care is delivered. And it is voiced as a need for doctors and health institutions being more open to patients are self responsible. This easily translates into the idea of patients being consumers.

The case I refer to here is based on work done in the period under the previous government, that is before 1 January 2007. During this previous government the emphasis was on measures to enhance efficiency and transparency of information and organisation. This was done through a new administrative regime called DBC (Diagnosis Treatment Combination) and through restructuring the law on the collective health insurance policies. This DBC regime defines treatment as a service related to a particular diagnosis. In that way patients are to get better information on the performance of hospitals and the quality and effectiveness of individual doctors. The change in the regulation on health insurance allows patients to change their insurance policy every year, so they pick the

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insurance company that fits them best (quality / cost). All financing, including the financing aimed at knowledge development and dissemination through professional bodies and consumer organisations in health care is now in the hands of the insurance companies. Previously this was done by government. Insurance companies now have a completely new role - besides procurement of care they also have a role in the continuity of care for their clients.

The new government (as of march 2007) has introduced a shift in policies again. This shift can be characterized as a shift from a free market orientation towards one that wants both free market orientation and to repair any damage or less desirable effects of market orientation. So it emphasises small scale care, improvement of care on the level of boroughs and more space for professionals as well as social entrepreneurs. Reactions in the health care sector itself around the time the new government was installed (march 2007) were positive about more funds being available and being recognized as crucial for innovation by actors in the sector itself (bottom up). On the other hand, there were concerns about the overall financing necessary and there was confusion about the character of the new policies since they seemed to support regression to policies of stronger regulation, where the health care sector was expecting more market dynamics and competition.

A (health)care organisation expressing a need for marketing.

During 2006 the author was hired by a client in the role of marketing / change management consultant. This client is an organisation consisting of a hospital and two nursing homes for elderly people. The institute is situated in a rural area in the Netherlands within a small town. The services are aimed to provide for the local people. The Hospital provides basic care and some specialities. Two of the specialities are exceptional and able to compete on a national level and beyond.

In a workshop, management discusses what they see as important with respect to marketing and what impact they want ‘marketing’ to have. The consultant points at the fact that no doctors are invited for this meeting. In this meeting marketing is seen by all as a must. It is identified as a periodic monitoring

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of ‘the market’ and adjustment of the strategy of the hospital. It is also identified as the right PR for the hospital in local media.

One of the nursing home directors, the one that later that year will leave, has a strong vision on how the nursing home - she is the manager of - should restructure the way care is provided. She calls it ‘care on visit’, which expresses her vision that people live in the home and nurses and caretakers visit them, when necessary or within a certain ‘contract’.

On the basis of interviews some more ideas about the need for marketing are formulated. This time the medical staff is involved. The medical staff wants marketing because they are worried about patients going elsewhere and competition taking over. Reasons for patients to go elsewhere, are analysed in different ways. Management wants doctors and workers to be more communicative, friendly and service oriented. Doctors feel the service level is not high enough and not advanced enough. Doctors want management to promote their (doctors) services effectively to the market. Middle management expresses a need for marketing, but is mainly worried about the track record of the organisation with respect to projects. Not many of them have succeeded, which they say is because of several factors, but mainly because of work overload in the primary process. Projects take away time that otherwise could be used more effectively for care.

Case description	
Client	• Hospital (cure) & Nursing Homes (care) • Rural area • Two locations • Cure: Basic, 35 Consultants, 120 beds • Care: 90 Psychogeriatric inhabitants (long stay), 90 Rehabilitation inhabitants (shorter stay) (stroke, rheumatism)

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Dynamics	• Board of directors just changed from two to one – as a result of crisis in relationship between management and doctors • A merger is planned for with two new nursing homes, from the idea to be able to offer the whole chain of cure & care • The clerk to the CEO who has a general role and a specific role in the area of PR is replaced by a new role holder. • A new Eye clinic has been realised in a very short time. It gets recognition nationwide. • Another innovative clinic (neurologists) is accepted for the sake of good patient care and PR, but resented for not making a profit and therefore being a burden to the budget.
Throughput time	10 months
Phasing	**Critical statements / incidents**
Intake	• CEO expresses the wish to develop marketing analysis and strategy, structural variables (marketing department) and awareness within the organisation of the changing demands and conditions in the environment.
Workingmodel	During the regular (three monthly) management staff meeting with doctors, the result of the intake is presented and a working model is agreed. • The doctors are extremely dismissive of management not

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	doing enough to make the hospital have more patients. • Management is blaming (some) doctors for not being more service oriënted and considerate with patients.
Organising the work	A marketing steering committee is formed of a cross section of managers and doctors, including the CEO. • Regular work meetings are held with the CEO and the consultant. • The marketing steering committee is split in two committees, one for hospital and one for the care homes. • Project manager for innovation attacks consultant and tries to sabotage his role • In a meeting with teamleaders (nurses) with the purpose to discuss 'marketing' and think it through, they are implicitly authorised by the hospital manager, to not do any extra work / spend time outside 'normal' workload.
Policies	• Two workgroups analyse the policies of care and service provided to patients • On the basis of this analysis, a marketing strategy is formulated.
Stakeholders	• Stakeholders (local government, patient representing bodies, GP's, insurance companies and banks, the regional healthcare internet portal initiative, other healthcare professional like midwives, ambulance service etc.) are invited to discuss future expectations and

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	demands for the hospital. • GP are invited to discuss future needs and expectations. • One on one meetings are held with the doctors practice groups and the hospital manager.
Handing over & Endings	• Strategy documents are handed over by the workgroups to the board. • The CEO organises a meeting in order to integrate the outcomes and set further action plans. • A new role holder for marketing is hired as a 'permanent' post.

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Part 2.

Transformation

Within the theme and leading angle of the conference Winnicott's thinking and concepts of **potential space and transitional objects** need to be central. Winnicott observed transformation in the new born baby as a process where 'me' distinguishes from 'not me'. Observations in the relation between the baby and the mother as it develops, where transitional objects play a role that can not be overlooked, once noticed.

From there I go in two other directions. One being transformation as the psychological work between **symmetrical organization and the asymmetrical organization of the experience,** concepts introduced by Matte Blanco and used by Civin in his analysis of relations and relatedness through internet. These to ways of organising experience are vastly different logical modes that are incompatible, but according to Civin relate through psychological work of transformation. The second direction being transformation as understood and worked with by David Goodmann and his colleagues. Goodmann has created a theory of transformation that supports his experiential work with organisations. Here transformation is purposefully worked at. Transformation is to facilitate progression in favour of regression. Desire is a key concept as a counterbalance to bureaucracy which isolates the organisation from the environment.

Winnicott

Winnicott speaks of transitional objects, transitional phenomena and potential space. He studied transition in early infancy. Transition was from a near state of union or fusion with mother to a phase when the baby – becoming infant - is able to discriminate itself and its mother as different beings (Ambrose pag. 8). Davis & Wallbridge[1] state Winnicott's contribution was 'in terms of the area of illusion or, as he also called it, the "potential space". He saw that very often the first special possession adopted by an infant has a particular importance that is allowed for by the parents. He called this the first not-me possession." tracing its origin to very primitive forms of relating and playing".

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[1] (D&W, pag 57).

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In the (health) care organisation there is a parallel with birth, if you look at the inevitable character of having to deal with the changing regulations. The potential space as an area of illusions e.g. between ‘me’ and ‘not me’ exists in many ways. It implies a transformation where the institution can discriminate itself from government, its representing bodies and other stakeholders. Potential space exists between organisational life that is regulated and not regulated in terms of type, volume and price of services. It exists between institute and government where the role of the inspection has changed into inspecting more on a meta level then in the direct execution of care related tasks. It exists between the institute and the insurance company, where previously the insurance company would be a reliable provider for financial deficits, but now it no longer is. It exists between the institute and the professionals where some are on the payroll and some are not, but are working through (fixed? Shirt-term)contracts. It exists between the institute and the patients. I know of a hospital where inhabitants of the region donated so much money that a MRI machine could be purchased for the hospital. At the same time these inhabitants have a choice to go to a different hospital if they need care.

The me - not me differentiation was present in conversation. Managers were saying things like: “The insurance company here is very helpful and has never let us down financially”. Or “We always do creative bookkeeping and find ways that the government is paying for the extra costs related to facilities” . Or “We are doing these projects within the agreements with the insurance company and although we are asked to do a proper report, we never do and still get the money”. And doctors were saying things like “the management is weak, they do not produce and do not provide when you need something”, or “this manager is always reacting in a political way, it always seems to be about power if you talk to him, with him it is to difficult to make things concrete.”

These quotes for me are related to the not differentiated situation of the very early child, where Winnicott speaks of the illusion of omnipotence.

“The illusion of omnipotence after all becomes delusion in the growing child or adult, so that where the absolutely dependent infant’s experience is preserved in consciousness we recognize madness. What

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is therefore vital in the individual's journey towards independence is not a continuation of the experience of omnipotence, but rather, a continuation of the capacity for creativity." (D&W pag 64).

A discussion with a group of paediatricians shows the meaning of this insight. Being the lowest in the hierarchy, the paediatricians always seemed a bit depressed when I saw or talked to them on any occasion. They had a small practice and were accused of not working at all, starting late, seeing not many patients. When talking to them together with the hospital manager on marketing, they expressed depression again in admitting they were not the big earners for the hospital (and actually not for themselves either when compared to other doctors). However when they were appreciated for, encouraged in and offered help for their creative research in connection to the nearest academic hospital, they changed.

Winnicott's helps me to understand that transformation is self defined. The baby or child is not aware of its transformation other then living the experience and understanding on hindsight what has changed in its relationships and how these relationships develop.

The new eye clinic – and the way it was created - was a boost in the transformation and helps to highlight difference and progress. It is a milestone that helps to redefine and discover changes in the working and relatedness of the organisation. It is a new object in the relation with the environment and the stakeholders, helping to understand and find out about ones position, impact and potential for influencing the environment. (Last sentence needs a bit of work)

The interest of the managing director and the head of medical staff in the production of a marketing strategy document, agreeing it would take considerable time and resources to make it, can be seen as cautiously acting in the potential space between old and new and between organisation and market. This document was seen as important for a long time and the process of making it was kept alive for a long time -longer then I would have expected. It was boring to make because of the analytic and abstract character of the work. Also it was clearly illusionary since it was only able to cover some aspects of the total complex picture. It felt like buying time. There seemed to be no need for making decisions as long as this work was going on. It seemed disconnected with everyday practical work. It

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seemed to split responsibilities for everyday production from preparing for the future, allowing them to be separate, disconnected. In the process of making the marketing strategy document, frustration and celebration were going hand in hand. The frustration was about not moving, the celebration was about the better understanding and clarity of the situation. Since acting was postponed, the strategy document seemed to have a different function.

Since there was such a clear interest in a marketing strategy document, I interpret it as an object with a function in the change / not change process. An object that was shaped from many discussions and exchanges between management and doctors on the basis of their questions and mental images of a future position in the market and what that would mean. Anxiety played a major role in the creation of the object.

There were other types of objects e.g. the consultant. Being projected upon as a new resource, role model, and loaded with hope for change, better communications, clearer policies, more recognition and help for achieving better results. Of course being the object of desire for some time created envy and destructive impulses as in the example of a particular project manager.

The hospital had appointed a project manager annex coordinator for the development of 'extramural' care. She was to coordinate projects that are funded by the insurance company outside the regular funding and she was to follow up on the developments of protocols in 'extramural' care – which is care that replaces second order care (hospital) with cheaper first order care (GP's). This role was new. The woman occupying the role was a former head of a nursing department. She was extremely well informed and had good connections with GP's. Predictably she was seen by the hospital doctors as bossy and interfering with doctors business. The consultant was given a lot of credit for his previous work in consulting in the process of building a new eye clinic. From that the image was created in the organisation that the consultant was able to deal with and stand up to doctors and difficult ones in particular, since the eye-doctors had a reputation of being impossible to work with. On the basis of this image,the projectmanager expected the consultant to be a (super) manager who would solve all kind of implementation problems with doctors around projects she was held accountable for. This came to a point where she sent e-mails to management and doctors, saying that she had agreed with the

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consultant that he would do work that she then could blame the consultant for not having done, where the consultant was not aware of agreements in the first place.

The consultant was also being used as an in between agent for damping tensions and regulating anxiety between management and medical staff.

The new eye clinic was a transitional object. Built on a separate location and in a new way it is symbolic for being entrepreneurial, innovative in offering quicker services with less discomfort for the patient. This new clinic is something to be proud of and feeds the sense of being able to put a mark on the environment and beat the competition. “We are the first with this in the Netherlands” (eye doctor, hospital manager, PR clerk). It opened in a period where the PR person for the hospital had forgotten to send in the right information to a nation wide audit in the national press on ‘Where to find the best hospital”. Because the newspaper did not get any information, the hospital was last on the list.

3.2 Civin and Matte-Blanco

Civin builds on the concepts of the symmetrical organization of the experience and the asymmetrical organization of the experience, originally introduced by Matte-Blanco[2]. Civin adds the idea of transformation as connecting the two through psychological work.[3]

Symmetrical organization of experience is the organization of experience without hierarchy, logical order or timeline being involved. This experience relates to an emotional (unconscious) level or a dream-like state where everything and everybody can be related at the same time. Asymmetrical organisation of experience is the organisation of experience in an opposite manner through logical relations in order and time.

According to Civin transformation is the psychological work done in connecting the two forms of organisation. In his book ‘male female email’ Civin relates these two forms of organisation to Kleinian theory. He quotes Turkle and Faber who he says see cyberspace as potential space (of progress and

[2] Matte-Blanco, I, The unconscious as infinite sets, quoted in Civin, Male Female Email (see bib.).
[3] Civin pag 63.

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growth) and within that the computer as the transitional object. He himself takes a different stand, saying it (cyberspace and the use of the computer as transitional object) could be developmental and it could be thwarting. (pag 37 – 40). Anxiety fuels the use of technology in the context of a larger social picture. He uses Kleinian object relations theory which states that 'in the face of profound persecutory anxiety, people strive to keep separate, and thus keep safe, aspects of experience that, if seen as a whole, would become wholly contaminated. At the same time, however safe this splitting apart may feel, many people retain a simultaneous desire for wholeness that contradicts the desire for security.' (pag 193).

In other words, the positive sense of development in the potential space through transitional objects, is not only positive. It can be thwarting as well.

Most people manage to deal with depressive anxiety and remain in the world of whole objects. Nonetheless, being vulnerable to excessive persecutory experience, many people also regress into a dedifferentiation (is this a word?) between human and non- human environments and a reversion to predominantly paranoid-schizoid organizations of experience (Civin pag. 197).

In one form of paranoid relatedness, persecutory experience is obscured through the veil of part-object experience that simulates whole object experience. The simulated experience of being a whole person once again dealing with other whole (or multiply experienced) people, facilitates the restoration of triadic experience that includes ,,,, in this way internet links become transitional links from the cell of withdrawal to the world of interpersonal engagement.

In another form of paranoid relatedness, however, life on-line emerges as substitutive for the qualities and characteristics of real life relatedness. In this version the anxiety of persecutory experience is also avoided, but the restoration of flexible triadic experience is subordinated to the maintenance of fixed and isolative ways of linking symmetrical and asymmetrical forms of experience.

Making the parallel to the transformation of (health) care: to what extent is marketing a 'technology' that may facilitate the experience of partial as if it is the whole? Or to what extent is marketing a type

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of cultural life that constitutes playful transition? Marketing can very well enhance regression in defensive routines, preventing(what?) from entering the potential space. Or it can be developmental, using the potential space for growth.

In order to answer these questions it seems important to look at two different aspects. One is the understanding of the experience of wholeness already in the organisation. The second aspect is the way marketing fits into these already existing dynamics on the basis of the mental images and projections on marketing.

In the case I am using, there is an observation of the head of medical staff, where he aggressively defends his own neurological clinic for the treatment of headaches, by saying that " Only in my clinic is medicine executed the way it should be executed, with the right time and approach to patients. If it loses money for the hospital I don't care." I see this aggressive defence as a need to maintain the identity of practicing as a doctor as it should be. And I think this defence also includes an experience or illusion of an experience of wholeness in including the relationship with the patients as very important.

The same doctor though is constantly attacking management and management of the nursing homes in particular for wanting a more inclusive and integral approach within the management of the whole organisation. This well articulated need for wholeness on another level, is not accepted by the head of medical staff.

These data give some insight into the experience of wholeness in the organisation and illustrate Civins point of part object relations being able to simulate whole object relations.

The second point is about the projections and mental images of marketing. To elaborate on this I think I need to say something about marketing as it is know in business. In business schools like MBA's, marketing is seen as a functional area or discipline of management. It is linked to commerce and strategy. Usually companies have organised their marketing needs through a combination of roles and structures. Roles that relate to the market (accountmanagers, sales managers, marketing managers,

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support departments for marketing research, communication, advertisement and PR) and structure in terms of communication and (physical) presence close to target groups of customers. The agenda for marketing as a discipline in general consists of research (market, competition, pricing, strategy), PR (industrial relations, branding, events) and support for building and maintaining customer relations (ICT systems /CRM, campaigns, creating marketing channels, loyalty programs, web-based communication). Usually marketing as a discipline is seen as different from sales.

In a way marketing (including sales) can be seen as an attempt to institutionalise transformation in a business. Through analysis, being well organised and structured as a function, following hierarchy, targets and roles, marketing facilitates change. Businesses now advocate that the only constant is ‘change’, putting marketing in a position of leadership and status. Practitioners of marketing can easily been seen as magicians, seducing consumers and cheating for the sake of luring consumers into buying things they do not need or even want.

Workers in the hospital case admitted (?) said (?)that they associate marketing with something artificial, something that is not dealing with real people, feelings, life and death, let alone the dynamics of relationships, relationships that are vulnerable because of the unequal power balance, dependency and human ‘qualities’ expected and required.

Yet these very same workers were eager to know the magic and tricks of business and expect business people to be able to create miracles in terms of attracting new clients, creating fame, attention, financial success and getting the job done.

If marketing can only be seen as an asymmetrical activity it can not be successful. This was seen in the case work. It was experienced that a blue print approach to marketing was more helpful to the people representing the culture of ‘fixing things’ in accordance with sound and scientifically accepted (para-medical) protocol. Professionals with a more communicative stance in their work with patients seemed less in need of a transitional objects with respect to marketing. Even more so, they seemed to demonstrate the defensive nature of marketing as a system, since in their opinion management tried to control them in not having contact with clients through feelings.

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On several occasions meetings were organised where stakeholders were invited to join and discuss marketing related issues. One meeting in particular was on a relatively large scale. The meeting was set-up in a playful fashion, where people were helped to see other people they did not know, without feeling forced to do so. It was rather informal and catering was involved. ?Fairly obvious to expect and say that this meeting was highly appreciated and seen as successful for new ideas, contacts and even initiatives came out of it, and some people explicitly referred to a sense of wholeness.

Goodman and group relations

Group relations conferences build on yet another concept of transformation. It comes from the psychodynamic view on groups as originally developed by Bion. Understanding basic assumption groups and working group functioning are key to this concept of transformation. It is the experience on a group (systemic) level that can be known through the individuals. An important role of staff is to formulate and share hypotheses about the group (system), its thinking and affects (both voiced and shown through individuals) in the here and now. These conferences however have different outcomes depending on the principles they are built on. (Experiencing?)The Leicester conference model is about experiencing change in relations and relatedness in the sense that the psychotic character of the starting conference (as a temporary organisation) is slowly changing into dialogue and a more differentiated functioning. The IFSI model is different in its application where its purpose beforehand is transformation. Goodman et.al. describe applying group relations conferences design principles in the workshops they conducted in a production company, where they work on the basis of their hypothesis that a transformation from 'envy to desire' [4] is taking place and necessary in order for the survival of the company. Goodman et. al. state that desire 'literally means 'to stop gazing at the stars' and hence 'to feel the loss of', or 'to long or hope for'. Putting desire as an affect that 'consists in having one's feet (back) on the ground, no longer being star struck, moving again, being (once again) in reality. The authors then continue saying that envy is another possible response to lack, but unlike desire, which can initiate a constructive process, envy harbours destruction. According to the authors the workshops

[4] Pag 155, Group Relations, Management and Organization, French and Vince, 1999

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in the production company - on the basis of group relations conference design principles - created desire from envy in a three staged process: 1. Sideration a stage of deadlock, the ideal of the other becomes ones ego ideal, ones free will vanishes, 2. Consideration where it is about accepting that processes of identification be directed not towards a single leader, but towards many. 3. Desire, where life is regained allowing each and every one to rediscover his or her own identity, integrity and singularity as a human and social being and to allow his or her own specific desire to come through as another response to the question of void and lack.

In another place[5] Goodman states that transformation inevitably consists of zigzags of progression and regression. Transformation as a passage, a journey. The inevitability of regression following progression and vice versa. Goodman relates the zig-zag to the difference between 'survival and living'. Living is accepting the passing of time and therefore consciously travelling from one state to another with other people. Survival being a banal existence trying to suspend or annihilate time, , repeating everyday the previous one, therefore clinging on to suffering.

Looking at the marketing case from a group relations angle brings two reflections:

The first is the basic assumption process as it is known to manifest itself where members project on authority figures their fantasies and then act as if the fantasy is what determines behaviour - or the other way around. [6] What this has to do with transformation in an organisation is clearly demonstrated by Goodman et al. from their work in a production company.

Going back to my/the consultant's (are you writing as I/my or as the consultant?) own marketing assignment the consultant aimed to work with management and doctors in joint meetings. At some point in a discussion between the managing director and the consultant, it was stated by the director that 'you have to be able to cope with the attitude of the doctors (that is constant criticism, arrogance and selfish behaviour), otherwise you should not work in health care.' On several other occasions similar remarks were made by the director but also by other managers. A revealing statement by the

[5] Psychoanalysis and management, the transformation, David Gutmann with Oscar Iarussi, Karnac, 2003.
[6] Pag 159, Kahn and Green, Seduction and Betrayel: a process of unconscious abuse of authority by leadership groups, group relations reader 3, Edited by Solomon Cytrynbaum and Debra A Noumair, A.K. Rice 2004.

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director in a meeting later in time where the director was present with his future colleague and the consultant, was that 'they were now in a position to 'get them' (meaning the doctors).

The style of the director is one of laissez faire, of being absent, of putting effort in projects outside the primary task (building projects, merger etc.) His presence is one of not showing or sharing affects. The hypothesis is that the projection of negative (so to speak?) 'doctors qualities', creates an 'as if' style of management where management becomes primarily concerned with dealing with, pacifying and surviving doctors behaviours instead of working on the primary task.

More evidence that this splitting is present and hindering the work on the primary task, is:

- in the very first meeting with the management, doctors were not invited.
- one doctor complained to the consultant about the hospital manager that he is always political and that you cannot do business with him. Because of this defensive behaviour the doctor said he would work without the manager or find ways to get his way working around the manager.
- the manager of facilities was criticized by his colleagues for always giving in to the doctors. Unfortunately for him his behaviour in dealing with the doctors was not more or less bad then the behaviour of the other managers, but his acts always had material and therefore financial consequences.
- the secretaries openly commented on the managers as not being strong, not taking a position and not being able to work well with the doctors. This was said to the consultant by the secretaries, on several occasions.
- at the same time the consultant aimed at differentiating roles by addressing different tasks for managers and doctors. Managers with respect to the services provided and the functioning of the non clinical aspects of the organisation. Doctors with respect to innovation in clinical treatment.

The stereotypes / mental images about (health) care are the stereotypes of the professions involved. The nurse is always nice and ready to help, give comfort and be there. The doctor never has time, is a nerd and is only interested in his or her own status and money. Hospitals and or homes for elderly are

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places you do not want to be. You are there with anxiety that you are not invited to talk about. The places are impersonal, busy, impractical, and you always have to wait and most of the time without anything worthwhile to enjoy or look at.

These (and other) mental images create basic assumptions in and between subsystems, that can enhance ‘as if dynamics’ and will hinder transformation. Working on projections is a prerequisite for transformation.

In a group relations conference, experiences in intergroup- and or institutional events show that basic assumptions create difficulties in performing the task of investigating relations and interrelatedness. Where training groups are offered in conferences, the two conference subsystems take some time to differentiate. Even in a last plenary members may chose to mix between the subsystems. It can happen that a training group, after the individual members have been authorised as consultants, struggle (or even stop) to organise themselves to keep working as a subsystem. This can be seen to create difficulties in the role of consultant in application groups as the place where training group members can act as consultants. In the Leicester conference of 2007 where I was a member of the advance practice subconference this was the case. It was understood that part of the ‘management’ in the mind explaining the behaviour of the AP members was that they worked from the idea and experience outside the conference that consultants work individually. What it means to manage the consulting role other then working through the consultants team experiences and ones individual role as a consultant, was a learning experience.(This para. needs to be more clear I think.)

The parallel with the marketing case is that the hospital manager and the consultant talked with many of the doctors in the context of their individual practices. What the doctors need to work on among themselves in order to be able to perform their role in the best possible way was not duscussed.
The tensions and issues between the doctors were not worked through and must therefore have hindered work on the task. The implication of this situation is that the organisation as a whole is not able to transform.

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This was the case in the Leicester conference in the Advanced Practice sub conference up until the very moment where the director took a stance and gave the AP members the choice of working on their issues or collectively being disauthorized.

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Part 3.

The object of marketing

By now it is clear that it makes sense to define the object of marketing in the situation of a hospital / care organisation within the changing landscape of Dutch healthcare wider then 'just' from a 'management' perspective.

The situation Dutch healthcare organisations are confronted with on the level of government regulations is one of multiple realities, with one leg so to speak in a relative unrestricted financial regime and the other situated in an almost opposite situation. So it has created a hybrid situation, which in itself is seen by some as transitional and by others as permanent.

The challenge for marketing defined as acting upon new relations and relatedness in a more self responsible economic position, can be understood, and can be put into practice in a creative way through connecting to stakeholders, but there are problems.

Authorisation

Development of 'the child" requires a role of the mother, the good enough mother as Winnicott calls it. The mother (government) has a difficult position. She has many babies and in realising that she outsourced the job partly to insurance companies and health inspection. She also created a situation where she has no control anymore over new births in a sense that mothering does not take place or has to be provided by another agent. In the new world the mothering goes from 'smothering' to no mothering at all.

In the case I was asked to help with marketing. In the negotiation of the contract we agreed to change the role title from marketing manager to 'quarter master for marketing'. Which I did with the fantasy that the role title would express shared responsibility. At the same time one could say we (I) created a role in between management and consultancy (and in between management and doctors), in which I

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could not be held fully accountable for ‘results’ in terms of measurable changed outcomes in the transaction with the environment.

This can be illustrated as well in the situation of the program manager. In her three roles she is suppose to create new ways of working in the absence of institutional relations and in roles with limited or confused authorisation.

Boundaries

Although there was a great struggle to accept and learn to work with the notion of being accountable for the survival of the organisation and its services (which is different from being responsible) some key people seemed to start to act more in an interdependent mode in ‘the organisation’, that is: work with and trust on colleagues more, instead of being dependent on government regulation. Seeing that staying dependent on government support is getting more and more risky.

Other professionals and workers in the organisation seemed reluctant to work through the question of what kind of organisation this is or should be, how it works and how one works with and in this organisation. Doctors are in a double bind of the call for transparency and adapting to policies of hospital management on the one hand and keeping strong ties with the existing lines of authority with their colleagues and peers outside the organisation. Depending on the type of discipline doctors are put in a position of more differentiation and less cohesion as a group as a whole. If doctors want to ‘do something new’ on a local level, they have to make their case and put their request well documented in front of a commission of colleagues, that can decide. The criteria used are mainly scientific. So adjustment in your practice so you have more time for your patiets or adjustments in terms of using not directly scientifically proven approaches, eg. combining specialist care in new ways with paramedical care is restricted. It is unclear what effect this has on the cohesion of their group or on the organisational relations.

Socially constructed control and defense systems

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Adjustment in the political arena of today results in pushing changing laws and regulations. How do you work through projections under such circumstances when at the same time management pressure is to be more in control of effectiveness, efficiency and costs?

Just recently it became clear that the amount of people claiming health care but not being insured is growing. It became clear that the amount of patients dying unnecessary because of so called avoidable medical mistakes is considerably high, despite the investments and efforts in health safety systems.

It seems that at the moment certain basic assumptions are dominant collectively. This problem is as real for health care as Cooper and Lousada have articulated it for the sector of social welfare. As they state in a rather convincing manner that in social welfare responding to demand is confused by responding to socially constructed inspection- and control systems. Therefore these inspection and control systems create alienation from and confusion within the adaptation that is required in the execution of the primary task.[7] A teamleader nurse recently appointed in the job expressed how she had expected a very different role / task when she was starting. She had expected to be able to work on innovation. But she said 'well I quickly learned that the only change we work on is the ever new task given by the inspection in building control systems'.

The pressure from new regulations and acting more independently paradoxically pushes in the direction of complying with socially constructed control systems and stay with the pack. For real innovation and connection to stakeholders some independence is needed to not only survive but also be creative in the task.

Viable structural variables

How to distinguish between basic assumption and workgroup? Or when is working on structural variables a defense and when is it an innovation? Is the aim of consultancy to try to get rid of the zags in favour of the zigs to use Goodmans language? There is a need to work in the potential space, where transitional objects occur and where 'small' results testify of the transformation from the 'me to the not me'. There is a need to work in an integrated way supporting or even creating a sense of wholeness. There is a need to work through defences on a systemic level. But working on new management practices and viable structures is necessary as well, in order to contain the tasks, roles

[7] pag. 59, Borderline welfare, Cooper and Lousada, 2005.

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and in order to manage entropy, using means and machines in the work, that are part of the work and need to be sustained and used properly. Creating a new organisation is a complex task, - 'if the awareness of this complex task is there' then it is not easily articulated either in terms of the political, social, technological forces and processes; structural variables (as the size of the organization, its pattern of ownership, etc.) and the psychological factors that all play a role.

Using the same examples of the number of people uninsured growing and the number of people dying because of so called avoidable medical mistakes being high, it is clear that it is easier to hold individual health care organisations responsible and make them compete then it is to connect and share responsibility for health care work in difficult area's on a national level. It is interesting that a guru of the free market, the American business professor Michael Porter commented upon the changing regulations in the Netherlands as creating the wrong kind of competition[8]. Where Michael Porter is interested to facilitate competition on the level of the doctors competing on the 'content' of the treatment, he showed that Dutch government is stimulating competition on price and costs. Porter could show from examples in other health care systems that this angle does not support innovation and actually makes the whole of the health care system more expensive.

Solidarity and ethics

In case of the hospital as discussed the paediatricians – but not only them - associated marketing with doing unnecessary things for money, doing extra or surplus doctoring so to speak, that would directly go against their Hippocratic oath. However when discussing their research in the area of allergies and how they could make their knowledge more available there was a change. These doctors also showed the least interest in their own earnings[9].

The doctors working in the nursing homes showed a different attitude towards paying attention to the very vulnerable clients. Also since they were operating under a different financial rehiome they seemed to be more accustomed to creative bookkeeping in the system in order to be able to provide for unexpected or very vulnerable clients.

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[8] Michael Porter, National Health conference Leiden, December 2005.

[9] Two other specialists groups were more eager to take advantedge of the new regulations with respect to set up new practices with more capacity and more efficiency.

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The casualty in the plastic surgery where a 22 year old women who weighed 55 kg's came for a liposuction treatment and died during the treatment is seen by many doctors as an illustration of the discipline losing its professional responsibility.

Epilogue

In the presentation I have been looking at marketing in health care and defined it as "acting upon new relations and relatedness in a more self responsible economic position". In that way looking at marketing from a relational position (relations to stakeholders) and an economic / managerial position come together.

This is work in progress. The discussion has led to some interesting comments and ideas. Apart from work in other assignments, another aim is to organise a workshop in the autumn of 2007 (on the basis of group relations principles) for participants coming from different organisations and institutions in the health care sector.

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