

**‘For the sake of our customers’: A case study of the links
between Coordination, Communication and TQM**

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DEDICATION

For every parent who encourages their children to learn.

ABSTRACT

This study is a qualitative case study approach to theory building that aims to develop a more holistic understanding of the patterns of coordination in an organisation that has successfully implemented TQM using a communication perspective. The data were gathered at a large private hospital in Bangkok where 36 respondents from non-medical treatment areas were interviewed. The study used in-depth interviews as the primary data source, complemented with participant-observations and document analysis to address the main research question: In what ways have the effects of TQM on communicative attitudes and practices contributed to coordination?

Influenced by the notion of social construction, the analysis suggests that despite TQM consisting of several contributing principles and tools, it is the role of leadership that demonstrated the most significant value to communication and coordination outcomes. Three key patterns of coordination emerge in the study: (1) shared meaning and common purpose derived from management's interpretation and articulation of TQM reality from a customer perspective, (2) shared understanding as a result of management's construction of TQM influenced administrative arrangements, and (3) emotional experiences as a result of staff members' social interaction. The finding of this study suggests that achieving coordination is far more complex, and can be difficult to control by management, specifically one emerging from an emotional experience which was found to have more effect on staff members' decisions in investing or reserving their energy in coordination, as compared to the other two patterns.

The findings demonstrate that organising coordination is not always rational and static, as previously discussed in the dominant organisation design-based literature. Rather, coordination is highly dependent on the process of social construction, communication, and interaction between organisational members. For this reason, the role of management in ensuring consistency in interpretation and construction of the shared reality, and in ongoing communication is imperative, not only to guide and

maintain coordinated actions, but also to achieve meaningful and mindful coordination of members within the organisation.

The practical theory developed in the study makes a direct contribution to coordination theory, specifically on the emergence of multi-dimensional coordination patterns which suggests the need to reconsider a research approach that could accommodate the complex nature of coordination which is also driven by communication, social interaction, and reciprocal relationships. Future studies on coordination could be positioned within a relativist, constructionism or interpretivist paradigm and investigate interrelated multiple ontological domains, not only the conventional organisational structure, but also cognition, discursive and social interaction. The study also offers some useful insights into both coordination and communication aspects for practitioners who aim to successfully implement TQM.

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Chapter 1

Introduction

This chapter provides an introduction to the thesis. It begins with the study's research background which serves as a springboard to the study's research agenda which focuses on the underdeveloped links between coordination, communication and Total Quality Management (TQM). This chapter then provides the study's context of investigation and its rationale; the research question and research design; significance of the study; and the selected organisation as a case study and its contextual background. The chapter will conclude with a description of the organisation of the thesis.

1.1. Background to the Study

This section explains how coordination, communication, and Total Quality Management (TQM) became the key constructs of this thesis, taking account of the fact that the endeavour of this particular study initiated from a limited understanding of the "cross-functional coordination" aspect of the concept of Integrated Marketing Communications (IMC). Cross-functional coordination is seen as both a key success factor (e.g., Pickton & Hartley, 1998; Kliatchko, 2005; Shimp, 1997) and a barrier (Eagle, Kitchen, Hyde, Fourie, & Padiseti, 1999; Kitchen & Schultz, 1999) for IMC, given that the ultimate goal of IMC is to achieve a clear and consistent message in communicating with a company's internal and external stakeholders (Schultz, Tannenbaum, & Lauterborn, 1996).

In recent years, IMC has increasingly been challenged over its legitimacy as theory-in-practice (Cornelissen & Lock, 2000). Pettegrew (1999-2000) observed that, "The

widespread attention paid to IMC is largely a function of its strong intuitive appeal—it makes good sense”, but raised a critical question, “If IMC is so good, why isn’t it being fully implemented?” (p. 29). He further argued that IMC literature often fails to integrate issues of the organisational context, which influences the way people communicate and interact, into its theory.

Despite the lack of empirical evidence related to characteristics of organisational context that could be conducive for IMC implementation, some IMC scholars have observed that an organisation that has successfully implemented TQM has a higher potential to effectively implement IMC (Gronstedt, 1996; Gronstedt, 2000; Lin, 2000-2001) because TQM is built on a fully integrated management effort with a great emphasis on the processes of inter-departmental cooperation (e.g., Deming, 1986; Juran, 1991). Several scholars also share the view that TQM could facilitate coordination, cooperation or collaboration between employees (e.g., Dean & Bowen, 1994; Marshall, 1995; Detert, Schroeder, & Muriel, 2000).

The study’s initial plan was to investigate how the contextual condition of an organisation that has successfully implemented TQM could be supportive of IMC, particularly its cross-functional coordination element. However, the primary focus of the investigation shifted, because the existing literature of coordination offers a limited view and approach to assist the researcher’s understanding of and identification of characteristics and patterns of coordination. In addition, it was also found that the existing literature of TQM provides little empirical evidence to support the previous claims made for TQM and its contribution to coordination.

The body of knowledge of IMC is still developing (Schultz & Kitchen, 2000) and the integration of knowledge from other multidisciplinary areas including coordination and TQM is likely to make a valuable contribution to the development of IMC and turning IMC into a theory-in-use (Argyris & Schon, 1974). Therefore, the research focus shifted to a more preliminary issue of *investigating the nature and characteristics of coordination* within a TQM context. It was hoped that the findings obtained from the study would shed some light on the understanding of IMC’s cross-functional coordination.

1.2. The Context of Investigation and Its Rationale

Coordination is a broad term which can have specific meanings in different contexts. In general, according to Merriam-Webster's Collegiate Dictionary (2004), the idea of coordination is:

Coordination (noun): (1) the act or action of coordinating; and (2) the harmonious functioning of parts for effective results.

To coordinate (verb): (1) to be or become coordinate especially so as to act together in a smooth concerted way; (2) to bring into a common action, movement or condition

This study focuses on coordination that occurs within an organisational or intra-organisational context. Nevertheless, the definition of coordination used in an organisational context can be different to some extent and often depends on how coordination is perceived by research scholars in their empirical studies. Chisholm (1989) observed that some writers focus on coordination as a "process", whereas others focus on the "end of desired state" such as goal achievement. He argued that coordination should be seen as both "process" and "end of desired state" in order to provide a complete understanding of coordination. When coordination is seen as the end of a desired state, it "does not assist us to understand how coordination is achieved" (p.28).

Therefore, for the purpose of this study, coordination is defined as *the process through which parts and actions are organised in ways that enable goal accomplishment* (Chisholm, 1989; Malone & Crowston, 1994). This definition not only covers both the "process" and "end of desired state" elements of coordination, but also the fact that the definition is loosely described provides flexibility to accommodate additional characteristics of coordination which may emerge in the study's investigation.

Several researchers have expressed their disappointment concerning the slow development of the body of knowledge of coordination which lends little support to practitioners who struggle to coordinate (Heath & Staudenmayer, 2000). Coordination is often discussed as a mode of control (Alter & Hage, 1993; Malone & Crowston, 1994; March & Simon, 1958; Tushman & Nadler, 1978) and is primarily underpinned

by organisational design theory (Galbraith, 1973; March & Simon, 1958; Thompson, 1967). However, Heath and Staudenmayer (2000) saw organisation design as “old theory” but admitted that the literature is struggling to provide ways to manage coordination without the benefit of the structure and systems available in the traditional hierarchies. Similarly, Bolland and Wilson (1994) criticised the traditional approach to coordination as “a rather pedestrian and one-dimensional view of a complex issue,” noted that “alternative approaches were slow to develop,” and that “even when proposed were not completely satisfactory” (p.341).

In a rapidly and changing business world, organisations need to be adaptive to new environments by adopting new business philosophies and strategies to stay competitive, and coordination is one of the crucial issues behind the success or failure in such an adoption. Therefore, the primary aim of this study is to *explore characteristics and patterns of coordination in attempting to develop a better and more holistic understanding of coordination.*

To obtain alternative aspects of the patterns of coordination, apart from those identified within the dominant organisational design perspective, this study proposed to investigate coordination from a “communication” perspective. Although, to the researcher’s knowledge, coordination has not yet been studied exclusively from a communication perspective, communication is often treated as one of the key aspects of coordination in several empirical studies on coordination (Argote, 1982; Gittell, 2000; Morh & Nevin, 1990; Van de Ven, Delbecq, & Koenig, 1976). Some scholars also have emphasised the lack, or presence, of communication as the key factor that impedes or enhances coordination (Chisholm, 1989; Gittell, 2000; Minssen, 2005), suggesting that coordination means being involved inherently in communication activities (Ballard & Seibold, 2003; McPhee & Zaug, 2000).

The study’s research agenda becomes more salient when considering the underdeveloped link between coordination and organisational communication theories. The organisational communication literature is thus integrated into the development of the conceptual framework that guides the study’s investigation and data analysis. The review of organisational communication literature suggests a high potential for developing a broader and more holistic understanding of coordination

because several forms that coordination may take were observed from the review of organisational communication literature.

To explore the characteristics of coordination based on the links between coordination and communication identified through the literature review process, this study used as a context of investigation an organisation that has successfully implemented TQM. Although it is not necessary that an organisation adopts TQM philosophy to have good intra-organisational coordination, the philosophy of TQM places a strong emphasis on a systematic, company-wide approach. Given this, such issues should be more salient to managers in a TQM organisation and thus suggests the possibility of more holistic thinking about coordination activities within TQM organisations. More importantly, studying coordination within the TQM context has the potential to make a contribution to TQM literature. This is because, despite the link between TQM and coordination being identified in TQM literature (e.g., Deming, 1986; Dean & Bowen, 1994; Detert et al., 2000; Juran, 1991; Marshall, 1995), the empirical evidence that supports such a claim is relatively limited.

Besides the possibility of exploring of the link between TQM and coordination discussed in the previous paragraph, another rationale behind the selection of TQM context derives from the existing empirical evidence on TQM and communication, suggesting another possibility to investigate coordination from communication perspective. For instance, Lewis (2000) found that TQM's activities such as teamwork, problem solving and continuous improvement have improved the amount and effectiveness of communication between staff members. Fairhurst (1993) found that the use of vision means an organisation has to communicate more for attitude and behaviour alignment. Gronstedt (1996) and Lin (2000) shared similar findings in their studies that some ideas of TQM such as creating a constancy of purpose and instituting training (Deming, 1986), as well as some methods of TQM such as flow charts, check lists and benchmarking can help organisations improve their communication performance. These empirical findings may help to fill in the gap of the understanding of TQM and its relation to coordination through the investigation of the relationship between TQM and communication.

1.3. The Research Question and Research Design

This study aims to develop a better understanding of the characteristics and patterns of coordination through a communication perspective. Based on the rationales discussed in the previous section, the main research question of the study asks:

In what ways have the effect of TQM on communicative attitudes and practices contributed to coordination?

This research question is asked following some potential overlaps for the study's research opportunity identified from the review of literature on the observed links between three key constructs: coordination, organisational communication and TQM. There are two main reasons that this study has one broad research question. First, it offers flexibility to explore underdeveloped links between the three constructs. To the best of my knowledge, previous literature references and empirical studies have not yet addressed or studied the three constructs of coordination, organisational communication and TQM together. However, while having a broad research question offers flexibility to observe the relationships between the three constructs, this flexibility has its boundary. This is because the research question concerns two sequential relationships: (1) the effects of TQM on communication and (2) the understanding of such effect on the characteristics and patterns of coordination.

The second reason relates to the type of knowledge the study aims to produce. Although two separate questions (following the above two sequential relationships) can be asked instead of one research question, the use of a broad research question is seen as suitable for the type of knowledge that the study seeks—that is a “practical theory” which is described as a localised knowledge of a particular phenomenon, in a particular social context (Argyris & Schon, 1974). Using one broad research question allows the constructed practical theory to be present logically and holistically.

To address this research question and obtain a practical theory of the phenomenon examined, this study was conducted in an exploratory mode. Its research design is based on Eisenhardt's (1989) case study approach to theory building. To accompany the theory building case study approach, this study adopted a single-case, embedded

design (Yin, 2003) based on Eisenhardt's suggestion that a single case study is most appropriate for theory building purposes. The case study uses mixed-method data collection including semi-structured in-depth interview, participant observation, document analysis and a questionnaire survey. Although the study relies primarily on qualitative data, and semi-structured, in-depth interviews in particular, some quantitative data are also used for a complementary purpose, with the intention of minimising any possible bias inherent in the qualitative methods. The detailed discussion of the study's research methodology is provided in Chapter Three.

1.4. Significance of the Study

First, this study aims to make a contribution to the literature of coordination by offering communication as an alternative perspective for investigating characteristics and patterns of coordination. Based on the literature review, the communication perspective suggests coordination is constructed by communication, either through technical or human activities. By taking this view, it can enrich the current coordination literature which some scholars have criticized for offering a traditional approach and limited view of a complex phenomenon like coordination (Bolland & Wilson, 1994; Heath & Staudenmayer, 2000).

Second, as this study selected an organisation that has successfully implemented TQM as its context of investigation, the findings of the study provide empirical evidence about the theoretical linkage between TQM and coordination previously suggested by some TQM scholars. In addition, the design of this particular study has allowed an in-depth investigation of how a global concept like TQM is being practised in a real-life context. The findings of this study may provide some useful insights into both coordination and communication aspects for practitioners, who aim to successfully implement TQM.

Finally, the significance of this study derives from the unexpected discovery of the usefulness of the social construction approach (Berger & Luckmann, 1996) during the iterative data analysis. The notion of social construction provides a valuable insight to the interpretation and data analysis of coordination from a communication

perspective, which sees coordination as constructed by communication. The view from social construction furthers the communication-oriented view by suggesting that coordination is a process of social interaction and meaning construction between staff members (Shotter & Gergen, 1994). This additional view from social construction enriches the data analysis because it recognises the active role of participants as “social actors” (Berger & Luckmann, 1966). The view from social construction thus adds a *social interaction* aspect into the original proposed investigation of coordination from communicative attitudes and behaviours. Therefore, the application of social constructionism provides not only a theoretical contribution to the coordination literature, but also a practical lesson to the researcher to be more reflexive, flexible, and most importantly, to be more tolerant to the complexity of the data obtained in the real-life context.

1.5. The Selected Case Study and its Context

The selected organisation is a large private hospital in Bangkok, Thailand. The hospital passed the case selection criterion as representing an organisation that has successfully implemented TQM¹, not restricted to certain types of organisation, or a healthcare context. In other words, the selected hospital was selected for investigating the characteristics of coordination as described in the general intra-organisational context, not in the specific context of medical treatment coordination.

For this reason, the area of investigation was limited to non-medical treatment: “back office” and “front office”. The back office consisted of administration, TQM, human resources, education and training, accounts, and marketing. The front office was the customer-support service department. Within this department, there are several units including customer service, a call centre, an international patient centre, security, catering, maintenance and housekeeping.

The hospital initially adopted a TQM intervention program in 1997 both to improve its service to its customers and to improve the quality of medical treatment, and has

¹ The details of the justification for case study selection are addressed in chapter three.

continued implementing the program until the present. The success of the TQM implementation was evident when the hospital achieved a national Hospital Accreditation (HA) certificate in 1999. In 2002, the hospital achieved a Joint Commission on International Accreditation (JCIA) from the Joint Commission on Accreditation of Healthcare Organisation (JCAHO), which made it the first hospital in Asia to be accredited by JCAHO. The commitment to continuously improving its quality has also helped the hospital to be reaccredited by Thai HA and the JCIA in the following term.

In addition, the hospital is widely accepted nationally and internationally as a “best practice” organisation and has been adopted as a benchmark for its “best-in-class” quality improvement practice among public and private health care and non-healthcare organisations which are currently implementing a quality initiative program. Recently, it has been named one of the “top ten world leader” hospitals by Newsweek (Cochrane, 2006). The hospital is thus seen as one of the outstanding TQM exemplars, which potentially allows the researcher to develop a fuller understanding of the phenomenon under investigation. Apart from these advantages, the hospital staff also showed their willingness to participate in the study and endorsed the proposed scope of the study.

Although this study will not specifically focus on the healthcare context, an overview of TQM in healthcare organisations and the Thai context is provided here to serve as a contextual background for the case setting.

1.5.1. Total Quality Management in Healthcare

TQM has been implemented in the health care industry since the 1980s (Sheaff, 2002). The increasing attention of western hospitals to quality improvement is due to government influence, the influence of customers and other stakeholders, and hospital management initiatives (Kunst & Lemmink, 2000). In the health management literature, TQM can be defined as a system or process to improve both efficiency and quality through continuous improvement of the delivery of patient care and also of the organisational processes, where quality is defined broadly to include not only clinical dimensions but also financial, administrative and patient satisfaction measures (Anderson & Daigh, 1991).

Ovretveit (2000) discussed the differences between health care and many other industries and considered the requirements for effectively implementing TQM in health care organisations, particularly in hospitals. He saw doctor involvement, quality leadership, computer support, better training, structured team-working, communication and measurement as critical for TQM practice. Research on TQM has been conducted extensively in many hospitals and shows that TQM leads to higher business performance of the hospital and to a higher perceived service quality by patients (Kunst & Lemmink 2000; Motwani, Sower, & Brashier, 1996). In Aghazadeh's (2002) study, TQM was found to result in a higher level of quality and customer satisfaction.

Ennis and Harrington (1999) found the main benefits of TQM for hospitals were the improvement of patient/customer satisfaction and an increase in quality awareness. In addition, they also found employee morale and communication was improved. A survey conducted by Chow-Chua and Goh (2000) among hospitals in Singapore found TQM resulted in improving the quality of work life, reducing waiting time, a more efficient work flow, reduced costs and an improved organisational structure.

However, there is also evidence of the obstacles to implementing TQM in healthcare organisations. Shortell, Bunnett, and Byck (1998) reviewed studies on the application of TQM in hospitals between 1991 to 1997, and found overuse or underuse problems associated with TQM implementation. They speculated that this problem was due to the lack of leadership involvement, which is necessary for cross-departmental collaboration. In another study, Shortell et al. (1995) found that among all of the obstacles to the application of TQM in health-care organisations, cultural obstacles were the hardest to remove.

Shortell et al. (1995) argued that there were three key obstacles to TQM practice in health care related to cultural issues: (1) the inward-looking nature of health-care organisations which means that they tend to focus more on the needs of care givers and professionals than on the needs of external customers; (2) the bureaucratic organisational structure of health-care organisations which impedes the concept of employee empowerment; and (3) the lack of senior management commitment to TQM

and that in most health-care organisations, leadership styles are based on command and control, rather than empowerment, or manager as coach model.

Creating a culture that is conducive and supportive of TQM practice is one of the most frequently mentioned obstacles faced by organisations attempting to implement TQM (Shin, Kalinowski, & El-Enein, 1998). Hu (2003) used a mixed method case study to explore a health care organisation in the US that implemented TQM organisation-wide to improve clinical quality and found that a supportive environment played a critical role in TQM implementation. Nevertheless, Hu observed that some resistance to TQM came not only from physicians but also from hospital administrators. Hu concluded that while TQM resulted in some cost savings and some behavioural changes, cultural change at the level of values and beliefs had yet to occur.

Zabada, Rivers and Munchus (1998) found two major reasons for TQM is failure in the hospitals participating in their study. First, physicians believed that they were already doing quality work and perceived TQM primarily as a cost-control mechanism. Second, employees were lacking in the ability to see beyond their own departments' goal to the broader organisation. Yasin and Alavi (1999) reviewed the status of TQM in health care and identified the obstacles to effective TQM as: physicians' involvement, time required for TQM's successful practice, delay in financial payoff, high turn-over in the executive rank, and the resistance to TQM change of employees.

1.5.2. Total Quality Management and Accreditations in Thai Hospitals

The quality management movement in Thai health care was originated from the 7th National Health Development Plan (1992-1996) which encouraged hospitals to implement quality management programs by offering short term funding for this purpose. Then in the following plan, the 8th National Health Development Plan (1997-2001), the Hospital Accreditation System was introduced and the voluntary Hospital Accreditation System introduced by the Thai Government (World Health Organisation, 2002). In 1997, Thailand's own Hospital Accreditation program (Thai-HA) was established with a mission to establish and maintain a quality of hospital services that is suitable to the Thai health care context (Supachutikul, Director of the

Institute of Hospital Quality Improvement and Hospital Accreditation Thailand, personal conversation, October 4, 2004).

Thai-HA was an adaptation of the accreditation schemes from the Canadian Health Services Accreditation (CCHSA) (Supachutikul, 1999). Quality improvement concepts such as Total Quality Management (TQM) and Continuous Quality Improvement (CQI) were utilised as a means to meet Thai-HA quality standards (Pongpirul, Sriratanaban, Asavaroengchai, Thammatacharee, & Laoitthi, 2006). However, the early period of the implementation of Thai-HA faced a major challenge from the 1997 Thailand economic crisis. Sitakalin (2003) studied how the initial group of 35 public and private hospitals, which joined the program and adopted TQM as the foundation of their HA program, performed their quality initiatives during the 1997 economic crisis and found that these hospitals still maintained their commitment to quality management, despite some hospitals facing financial difficulty. The researcher found that hospital managers appeared to be convinced of the long term benefits and that they were also convinced that external accreditation was required to ensure the reputation of their organisation in the community.

Healthcare providers seek accreditation, either voluntarily so as to gain a competitive advantage, or as a legal requirement, or because it is practically impossible to attract patients or payments without it (Sheaff, 2002, p. 178). There are two key perspectives commonly discussed in relation to the adoption of TQM or other innovative strategies. These perspectives are “institutional” and “strategic choice” perspective. The institutional perspective argues that TQM adoption provides social legitimacy benefits (Meyer & Rowan, 1977) whereas the strategic choice perspective emphasises the technical benefits of TQM (Child, 1997). In a survey-based study conducted among a sample of over 2,700 U.S. hospitals, Westphal, Gulati and Shortell (1997) found that early adopters customised TQM practices for efficiency gains, while later adopters gained legitimacy from adopting the normative form of TQM programs. When TQM adoption was driven by conformity pressures rather than technical exigencies, hospitals could realise legitimacy benefits, rather than technical performance benefits from adoption (Westphal et al., 1997).

This issue has been investigated within the Thai context by Rukhamate (2003). In a study of the International Organisation for Standardization (ISO) adoption in Thai public hospitals which included a survey of 844 public hospitals and interviews of 31 respondents, Rukhamate (2003) concluded that the majority of public hospitals appeared to adopt ISO as a result of the pressure from government policies, and from the normative pressure from those public and private hospitals which previously adopted ISO, rather than adopting ISO as a strategic choice. This finding is consistent with Sitakalin's (2003) finding that hospital managers appeared to be convinced that external accreditation was required to ensure the reputation of their organisation in the community.

1.6. The Organisation of the Thesis

The thesis consists of seven chapters, following Eisenhardt's (1989) process of "building theory from case study" framework which consists of seven steps, as listed in Table 1.1.

Table 1.1: Research Procedures of a Practical Theory Building Case Study

Step	Description
Step 1:	Formulating research questions, conceptual framework
Step 2:	Selecting the case through theoretical sampling
Step 3:	Designing data collection methods
Step 4:	Conducting the case study
Step 5:	Analysing data
Step 6:	Enfolding literature
Step 7:	Presenting a localised practice in a theory building format

Source: Eisenhardt (1989)

Chapter One provides an introduction to the thesis. It introduces the three key constructs of coordination, organisational communication, and TQM which informed the study's broad conceptual framework and the development of the central research question: In what ways have the effects of TQM on communicative attitudes and practices contributed to coordination? It provides a brief review of the research design and the background, contextual information of the selected case study, and the significance of the study.

Chapter Two is central to Eisenhardt's first step. This chapter reviews the relevant literature about the three key constructs of coordination, communication and TQM. The chapter starts with a review of the literature on coordination as it is the primary phenomenon of interest. From the review, it is established that there is a potential area of research opportunity derived from the observation of the equivalency between coordination and communication. The second section explores further the area of research opportunity by integrating the literature and empirical studies on organisational communication to assist with the understanding of coordination from a communication perspective. The third section focuses specifically on the study's selected organisational context of investigation, TQM. It reviews TQM literature in relation to coordination and communication. Through this sequential review, some potential overlaps are identified and the study's research question is raised to explore the underdeveloped links between coordination, communication and TQM.

Chapter Three details the methodological approach undertaken to address the research question. A practical theory building case study is explained and justified. The chapter documents research procedures including the design of data collection methods, pilot study, data collection and analysis techniques, and ethical considerations. It also introduces the notion of social constructionism which is later adopted to assist with the data analysis and interpretation. The chapter concludes with a discussion of rigour in the study and methodological limitations.

Chapters Four to Six present the study's findings from which the analysed data and relevant literatures (Eisenhardt's step six, enfolding literature) are discussed together. The findings are presented in a narrative style, guided by the notion of social construction. Each of these chapters highlights a different pattern of coordination. *Chapter Four* presents a pattern of coordination from "shared meaning and common purpose" as a result of management's interpretation and articulation of TQM reality. *Chapter Five* presents a pattern of coordination from "shared understanding" through the management's construction of a TQM influenced working environment. *Chapter Six* presents a pattern of coordination from "emotional experiences" through the process of social interaction.

Chapter Seven presents the practical theory of coordination within the TQM context. In this chapter, the key findings from Chapters four, five and six are conceptualised within the cognitive perspective which encompasses all the key findings. Following the presentation of the practical theory, key implications on the theoretical, managerial, and methodological context including directions for future studies which emerge from the practical theory are discussed. The chapter concludes with the study's limitations.

Chapter 2

Literature Review

The purpose of this chapter is to review the relevant literature within the area of the research problem and to identify some potential research opportunities upon which the research agenda and its research question was based. The review of the literature in this chapter follows through a logical sequence of the literature encompassing three constructs. It begins with the primary construct, *coordination*, followed by the emergent constructs of *organisational communication* and *Total Quality Management (TQM)*. As this chapter involves the review of three disparate areas of literature and that each of them involves a vast amount of literature, the analysed and reviewed literature is organised into categories to allow better comprehension and clearer presentation.

The organisation of this chapter is as follows. The first section reviews the existing literature and empirical studies on coordination upon which the research problem was based. From the review, it is established that there is a potential area of research opportunity derived from the observation of the equivalency between coordination and communication. The second section explores further the area of research opportunity by integrating the literature and empirical studies on organisational communication to assist with the understanding of coordination from a communication perspective. The third section focuses specifically on the study's selected organisational context of investigation, TQM. Building upon the understanding from the previous sections, this section reviews the literature of TQM, in relation to coordination and organisational communication. At the end of the chapter, it presents Figure 2.1 which summarises a logical sequence of the reviewed literature. The figure demonstrates the established linkage between coordination,

organisational communication and TQM, and the overlapping research opportunity from which the research question of this study was based.

2.1 Coordination

Much of the organisational literature on coordination stems from researchers and scholars of organisational design who focus on how to coordinate interdependencies between tasks by means of several coordination mechanisms (e.g., Galbraith, 1973; Thompson, 1967; Van de Ven, Delbecq & Koenig, 1976). This section begins with a review of the previous literature on coordination reflecting the dominant, traditional view influenced by organisation design. It then reviews coordination literature influenced by the emergent thinking of human relations. Given that much of the literature on coordination is observed to be influenced either by the dominant, traditional view of organisation design, or by the emerging view of human relations, the literature of coordination is reviewed and categorised into two main groups of *structure-based* and *human-based* dimension. This section concludes with a review of literature including empirical studies that inform the established potential area of research opportunity on the equivalency of coordination and communication.

2.1.1 The Structure-based Dimension

The early works and empirical studies on coordination have their foundation in this dimension, given that these works were pioneered by organisation design theorists such as March and Simon (1958), Lawrence and Lorsch (1967), and Thompson (1967). This structure-based dimension is thus seen as a traditional approach to coordination studies in which its fundamental notion lies in the role of hierarchical control in managing interdependency and uncertainty of activities within companies to increase performance and productivity (Lawrence & Lorsch, 1967; Thompson, 1967). Two of the prominent works on coordination and hierarchical control are from Barnard (1938), who noted the ability of organisational hierarchies to mitigate the uncertainty resulting from coordination and control of complex and interdependent tasks by creating cooperation and coordination among organisational members, and from Chandler (1977), who emphasised the significance of coordination in hierarchical structures.

In organisations, hierarchical controls are seen to institutionalise or formalise, interactions between organisational members, as well as to designate roles and clarify boundaries between organisational members (Van de Ven, 1976). Van de Ven also emphasised that formalisation makes the division of labour and the interactions between partners more predictable and allows joint decisions to be made more by rules than by exceptions. Hierarchical control can be seen to include elements such as standard operating procedures, command structure, planning, and rules which March and Simon (1958) identified as the key means for task coordination. Pondy (1977) saw task communication serve the common purpose of minimising communication, simplifying decision making, reducing uncertainty about future tasks and preventing disputes. Pondy's idea of minimising communication is similar to Galbraith's (1977) who referred to hierarchical controls as superior information-processing mechanisms in coordinating interdependent subtasks. This view implies that coordination is managed through a formalised communication structure.

One of the influential works on coordination which has its foundation in the traditional view of organisation design and continues to be used as a framework in coordination studies until the present is James D. Thompson's (1967) interdependent typology (Heath & Staudenmayer, 2000). According to Thompson's notion, coordination is bounded rationality—that is interdependence among units in an organisation is embedded in the logic by which they interact with each other to complete tasks. In other words, Thompson saw that interdependence underlies coordination and that the level of interdependence between staff members is directly linked to the degree of interaction required to complete tasks.

Based on this logic, Thompson proposed his interdependent typology which consists of three types of interdependence in working processes: pooled, sequential and reciprocal. *Pooled* interdependence denotes situations in which "each part renders a discrete contribution to the whole, and each is supported by the whole," is "coordinated by standardization", and employs minimum communication because it does not require any serial ordering of activities (Thompson, 1967, p.54, 64). It exists in alliance when organisations pool their resources to achieve a shared strategic goal, the common benefits arise from combining resources into a shared pool, and each partner uses resources from the shared pool. These relatively small interdependencies

entail low coordination requirements but provide partners with benefits from the pooled resources.

In *sequential* interdependence, the activities of each partner are distinct and are serially arrayed so that the activities of one partner precede those of another, resulting in a higher degree of coordination than in pooled interdependence. Coordination in a sequentially interdependent form thus goes beyond the pooling of resources to include the order in which the product or service moves from one organisation to another. The partner producing the original product or service has to perform the task as laid out in plans for the alliance, and the subsequent activities in the alliance then have to be performed in a coordinated fashion for the overall strategy to be successful.

Reciprocal interdependence occurs when units come together to exchange outputs with each other simultaneously. Such an exchange entails a pooling of resources by different units, but in addition, each unit is simultaneously dependent on the other because its outputs are the other's inputs. In contrast to pooled interdependence, reciprocal interdependence is more interactive and requires ongoing mutual adjustment by both units and continuous adaptation to each other's circumstances. Each unit must continually anticipate the other's output stream and communicate its own production schedule to the other. The reciprocal type thus encompasses the highest level of coordination.

The majority of empirical studies in coordination that adopted this the view from the structure-based dimension were often conducted in a positivistic paradigm and many of them often predicted the level of coordination through the level of interdependency, using Thompson's typology as a framework (e.g., Cheng, 1983; Cheng & Miller, 1985). Some studies applied Thompson's framework in different organisational contexts and the result often confirmed Thompson's view (1967) that the type of reciprocal interdependence which is the highest level of coordination is found more in service organisations, such as hospitals and airlines than in product manufacture because of the uncertainty of the working environment (e.g., Larsson & Bowen, 1989; Lemek & Reed, 2000) which require extensive coordination across the partners (Thompson, 1967). In some studies Thompson's typology was adopted to testify to the complexities associated with the interdependence of activities across working

units within an organisation (Ring & Van de Ven, 1992; Van de Ven, Delbecq, & Koenig, 1976). Cheng (1983) observed that many studies on coordination which are influenced by organisation design often arrived at a common conclusion that when the intra-organisational system is structurally fragmented, coordination is low; when it is structurally integrated, coordination is high.

The view of coordination from structure-based dimension was the dominant view on coordination when Malone and Crowston (1994) proposed their “coordination theory” which was defined as the still-developing body of “theories about analyzing group action in terms of actors performing interdependent activities to achieve goals” (p. 87). In his empirical study, Crowston (1997) adopted coordination theory as an approach to investigating organisational process design and analysing patterns of coordination. He found that patterns of coordination depend on various resources and the management of dependency between them and this reflects the fundamental idea of “contingency theory” (Lawrence & Lorsch, 1967). This suggests that the demands imposed by the task environment and the technical nature of the work which organisational members perform encourage the development of strategies to coordinate and control internal activities. Contingency theory thus provides a useful, logical explanation about the management of interdependency in organisations (Thompson, 1967).

Thompson’s “pooled” and “sequential” interdependence has some similarities with “administrative coordination”. Alter and Hage (1993) observed that “administrative coordination” has been extensively studied in health and welfare organisations and that much evidence exists to show that administrative coordination relies on formal methods of communication to achieve feedback of information, that is, regularly scheduled committees, written policies, planning and formal rules. In a study which was conducted in healthcare organisations, Gittell (2002) identified four mechanisms for intra-organisational coordination based on her empirical findings: *routine, information systems, meetings* and *cross-functional boundary spanners* or *liaisons*. This finding extends the previous view from an impersonal mode of coordination (administrative coordination) to include personal modes of coordination, such as meetings, supervisors and liaisons.

This view was also previously proposed by Chisholm (1989) whose empirical findings were obtained from a two year ethnographic study in two large public transportation organisations in US and revealed that informal coordination is more effective than formal coordination. One interesting finding is that better interpersonal relationships between staff members were found to increase the quality and quantity of communication flow. He found that sometimes in formal coordination, communication can be limited because staff members who have information do not have a channel or the authority for communication. The focus on the impersonal mode of coordination in structure-based coordination also raised concerns among academic scholars on its limitations in addressing human related issues such as conflicts and politics that could affect effective coordination (Heath & Staudenmayer, 2000).

2.1.2 Human-based Dimension

This dimension can be seen as an emerging area of coordination studies because many of the studies were made in the 1990s. Therefore, the empirical studies in which coordination is the primary subject of interest are relatively limited and still fragmentary. Unlike studies from the structure-based dimension which were often grounded mainly in organisation design theory, researchers whose coordination studies reflect this dimension often integrated concepts and theories such as *socialisation* (Tsai, 2002; Wooldridge & Minsky, 2002), *team* (Tranfield et al., 2005), *network* (Bolland & Wilson, 1994; Gittell & Weiss, 2004) and *communication climate* (Gittell, 2000; Wooldridge & Minsky, 2002) into their studies.

Overall, the key characteristics of coordination which are observed from studies in this dimension are often described in term of interaction, relationships and communication between staff members, and often applied to a small context such as a group or dyadic level. The characteristic of coordination in this human-related dimension is found to share similarities to Thompson's (1967) "reciprocal interdependence" which requires the highest degree of coordination through spontaneous interaction and communication between staff members or work units.

Among the studies that specifically focus on coordination, the work of Jodie H. Gittell (2000) on "relational-coordination" makes a valuable empirical contribution to this human-related dimension. Observing the reciprocal influence of communication and

relationships among airline ground crews in her study, Gittell coined the term “relational-coordination” which is characterised by *communication ties*: frequent, timely and problem solving communication, and *relationship ties*: helping, shared goals, shared knowledge and mutual respect (2000, p. 517).

Gittell’s later studies (2001, 2002, 2004) were able to explore richer understanding of coordination outside the dominant, structure-based dimension for two key reasons. First, both quantitative and qualitative research methods were adopted into her investigation, whereas the main stream of coordination studies, specifically those of the structure-based dimension, were often conducted quantitatively. Second, almost all of her studies were conducted within service organisations, hospitals in particular, in which staff members have to work in a highly uncertain environment and therefore these organisations exhibited more variety and complexity of characteristics as well as mechanisms of coordination.

One interesting finding from Gittell’s work, besides the evidence that relational coordination improved group performance (Gittel, 2000), is the significant role of communication and relationships between staff members that nurture coordination. The view of Gittell on communication and relationships directly reflects the concept of communication climate (Schneider, 1990). Several empirical studies on coordination found key elements of communication climate such as open communication, trust and relationships to have positive effects on coordination (e.g., Chisholm, 1989; Ensign, 1998; Wageman, 1995). This idea is also found in a conceptual work from Wooldridge and Minsky (2002) who gathered findings from previous empirical studies and offered the proposition that organisational climate and socialization processes facilitate the development of inter-functional coordination.

Some researchers called the coordination that occurs within the human process as “social coordination”. Vallacher, Nowak and Zochowski (2005) described “social coordination” as when two (or more) people are coordinated to the extent that the actions, thoughts and feelings of one person are related over time to the actions, thoughts and feeling of the other person. Social coordination in this way can be seen to derive from social relations when individuals are more likely to trust those with whom they have established good relationships. Moreover, the ability of key players

in a network to foster the network is important. Sarason and Lorentz (1998) acknowledge the role of co-ordinators who have no formal power but whose knowledge and personality are significant in enabling coordination.

Couch (1984) saw “social coordination” as a form of social order that involves social interaction between staff members. Couch further specified conditions for coordination to occur which include: (1) establish co-presence, (2) demonstrate reciprocal attention, (3) reveal mutual responsiveness, (4) create congruent identities, (5) build a shared focus and (6) devise social objective. Couch’s view reflects the concept of “social commitment” in which Carabelea and Boissier (2006) proposed as a mechanism for coordination. This view suggests how one can use social commitments to represent the expected behaviour of staff members playing a role in an organisation.

There is also a norm from the external environment context that can influence the patterns of coordination within organisations. This type of social influence is known as “institution theory” (DiMaggio & Powell, 1991; Meyer & Rowan, 1977; Scott, 1995). From the institutional perspective, coordination satisfies the need for organisations to establish legitimacy in a world that is socially constructed. This view assumes that staff members are likely to work together more cooperatively under certain rules and environmental conditions that the organisation instituted as a result of its adoption of certain concepts or values from the external environment. In addition to this, Scott (1995) saw the role of professionalism in representing legitimacy as powerful force that is supportive for coordination within institutions, given that workers are inspired to act professionally to comply with the institutional values they share and work cooperatively to achieve shared goals.

Finally, based on work from Weick and Roberts (1993), coordination is approached from a different view of group-mind and social cognition. Analysing patterns of connection between staff members on an aircraft carrier flight deck, Weick and Roberts argued that the quality of coordination should be seen to depend on how “heedfully” deck personnel relate to one another. In other words, coordination requires the “collective mind” staff members to work together to accomplish the task with alertness, attentiveness, and understanding (Weick & Roberts, 1993). Based on

their analysis, they argued that airline accidents represented a breakdown of social processes and comprehension rather than a failure of technology. The literature review in this dimension thus suggests that, with the involvement of humans, coordination is not a straightforward activity that can necessarily be planned and predicted.

2.1.3 The Research Problem and Opportunity: The Treatment of Communication in Coordination Studies

The current coordination literature and empirical studies are still struggling to provide ways to manage coordination without the benefit of the structure and systems available in traditional hierarchies (Heath & Staudenmayer, 2000). A similar observation could be made of the current understanding of company-wide coordination which is often addressed from the process of organisation design and configuration (e.g., Malone & Crownston, 1994; Thompson, 1967), a view influenced by the dominant, structure-based dimension. However, coordination is not the straightforward activity which is often portrayed in the traditional view of organisation design. Rather, as suggested from the human-based dimension, coordination is associated with human interaction, socialisation and communication.

Organisations can resist coordination for a variety of reasons including turfism (Alter & Hage, 1993), politics (Chisholm, 1989) and conflicts (Gittell & Weiss, 2004), and these reasons are likely to have a negative impact on Weick and Roberts' (1993) "collective mind", another form of human-based coordination. Given this, an understanding of company-wide coordination is needed to integrate the human-based dimension into current thinking. However, the fact that human-based coordination often involves reciprocal relationships between staff members, has led many studies in this realm to focus at a group or dyadic level, making little contribution on the holistic understanding of coordination.

Nevertheless, based on the literature and empirical studies reviewed, there is a potential overlap on the treatment of communication in coordination studies which provides insight to the development of a more holistic understanding of coordination. This is because, although the key characteristic of coordination found in the structure-based and human-based dimension is differently described, the issue of

communication is observed to encompass coordination studies in both structure-based and human-based dimension. In fact, the literatures reviewed seem to suggest that coordination cannot exist without communication.

A large number of existing studies have used communication as one of the key constructs of coordination. For instance, coordination research scholars used the amount of communication (Galbraith, 1973; Van de Ven, Delbecq, & Koenig, 1976), communication satisfaction (Morrh & Nevin, 1990) and frequency of communication (Argote, 1982) to measure or determine coordination outcomes. Gittell (2000) defined relational coordination as consisting of communication ties and relationship ties. In addition, coordination is seen as a conventional experience (Boden, 1994), where conversations are verbal and/or written interchanges that occur between two or more people (Ford & Ford, 1995).

Further evidence that explores the role of communication in coordination was found by researchers who addressed communication as a major barrier to coordination. Heath and Staudenmayer (2000) argued that coordination neglect is caused by inadequate on-going communication. Researchers who studied coordination from the structure-based dimension often address coordination problems as a result of inadequate information flow (e.g., Cheng & Miller, 1985; Ensign, 1998; Galbraith, 1973). Finally, in a recent study, Minssen (2005) used in-depth case studies to investigate internal processes of self-regulation in production teams, in which he characterised this form of teamwork as “discursive coordination”. He found that the challenge of discursive coordination is to generate density of communication. He concluded that success in self-regulated teamwork can be difficult to achieve because “communication is still unused” (p.8) in teamwork.

Based on the literature reviewed, it seems clear that there is an empirical linkage between coordination and communication which suggests that coordination can be understood through a communication perspective. The fact that coordination is seen as being involved inherently in communication activities (Ballard & Seibold, 2004; McPhee & Zaug, 2000) means that investigating coordination from a communication perspective is likely to allow the researcher to observe characteristics of coordination more holistically. More importantly, in one study (Perlow, Gittell, & Katz, 2004),

researchers observed that participants tended to struggle with a question on how they interact with others in order to complete a task. However, the respondents tended to respond better with questions regarding their communication activities. This has the implication that researchers may be in a better position to observe and interpret characteristics of coordination from communication related data.

This section has developed a linkage between coordination and communication. In the next section, this area of research opportunity will be explored further. It integrates the literature from organisational communication to enrich the understanding of coordination from a communication perspective.

2.2 Organisational Communication

The aim of reviewing the relevant literature on organisational communication in this section is to help the researcher explore aspects of organisational communication that could enriched the understanding of coordination from a communication perspective, specifically on some alternatives dimensions that coordination may take. This section begins with a review on organisational communication, in relation to coordination. It then presented the review of existing literature on organisational communication that were identified and categorised into six aspects which suggest to share some characteristics of coordination. They are: *organisation form and communication structure, meaning and action, discursive control, communication climate: leader-member interactions, conversation and workplace relationships and organisational and national culture*. This section concludes with the research opportunity for studying coordination from communication perspective.

2.2.1 Organisation Communication: Overview

There are some views of organisational communication that reflect the notion of coordination. For instance, Keyton (2005) argued that:

A more complete picture of organizational communication is created when we think of messages in a pattern of coordinated moves among organizational members.(p. 13)

Similarly, Krone, Jablin and Putnam (1987) saw organisational communication as consisting of patterns of coordinated behaviours that have the capacity to create, maintain and dissolve organisations. Stohl (1995) took the view organisational communication from a network perspective defined organisational communication as:

The collective and interactive process of generating and interpreting messages. Networks of understanding are created through coordinated activities and relationships that permeate organizational boundaries. (1995, p.4)

Larkin and Larkin (1994) treated “interaction”, one of the key characteristics of coordination, as central to communication within organisation, according to them:

Communication is not a thing. Communication is an interaction. The goal is not to make things but to cause successful interactions. For an organization to have successfully interaction, it is important to recognize the significance of formal and informal communication activities (p.91).

Bordow and More (1991) defined organisational communication as a system of actions “sustained through the shared meaning made by its participants” (p.4). In addition, Bordow and More saw the communication process as ongoing “sense making”, which, in the long run, leads to desired outcomes for the organisation. This view acknowledges organisational communication as both the process as well as the outcome, similar to Chisholm (1989) who saw coordination as both the “process” and “end of desired state”.

In fact, the notion “end of desired state” of coordination is observed to share a similarity to the notion of “common ground”, which can be seen as the “end of desired state” in organisational communication. Common ground focuses on the coordination between what a speaker means and what recipients understand. According to Clark and Brennan (1991), the development and use of common ground are achieved through a process of grounding in which participants try to establish that what has been said is understood. Two main factors shape the grounding process is “purpose” (what the participants are trying to accomplish in their communication) and “medium” (the techniques available for accomplishing that purpose).

Organisational members engage in ongoing communication in an attempt to reach a common ground, or shared meaning and understanding between each others. Senge (1992) called the form of communication that is based on shared meaning as

“dialogue” (1992) in which organisational members “participate in this pool of common meaning” (p.242). Based on the review in this section, it can be concluded that coordination is constructed by *communication activities* through the process of interaction and construction of common ground between staff members within an organisation.

2.2.2 Organisational Communication: Potential Aspects for Understanding Coordination

For the purpose of this particular study, the following review of literature on organisational communication explores six potential aspects for understanding coordination.

2.2.2.1 Organisation Form and Communication Structure

This aspect is seen to provide an understanding of the influence of organisation form on communication patterns, which may in turn, affect coordination patterns. The literature of organisational communication acknowledges the influence of the organisational context on communication activities within the organisation (Keyton, 2005; Miller, 2003). Organisation form and communication structure are inextricably intertwined (Jablin, Putnam, Roberts, & Porter, 1987). It is a pattern of interaction and coordination that links the technology, tasks and human components of the organisation to ensure that the organisation accomplish its purpose (Duncan, 1962).

The view of communication structure influencing and shaping communication behaviour and the interpretation scheme of staff members is also found in Giddens’ (1984) “structuration theory”. The theory explains that, over time, the communication structure that influence employees’ communication attitude and practices leads to the established codes, configured in workers’ minds through ongoing acculturation, and represent workers’ collective mental blueprints that guide organisational communication practice. In a qualitative study conducted within a community service organisation, Witmer (1997) found newcomers create new selves as they engage in the patterns and structures of the organisation, and those structures are recursively created by and create organisational actors through social interactions that are institutionalised and reproduced within the organisation. According to Witmer, this finding “places communication squarely at the centre of organisation” (1997, p.328).

However, as noted by Giddens (1984), although constrained by these codes, workers' ongoing communication actions can either reaffirm these codes and thus strengthen them or incrementally modify them and, indirectly, the thinking that influences communicative actions. In other words, communication rules and structures are simultaneously constraining and somewhat malleable (DeSanctis & Poole, 1994) as a result of the ongoing interplay between an organization's implicit and explicit communication codes and workers' thinking and action within the constraints of those codes (Lewis & Seibold, 1993; Poole & DeSanctis, 1990).

Miller (2003) offers three founding approaches on organisations that influence key characteristics of communication within organisations. These approaches are (1) *classical and bureaucratic*, (2) *human relations* and (3) *human resources*.

Table 2.1: Key Founding Approaches of Organisational Studies and Characteristics of Communication

Key approach to organisation studies	Key characteristics	Types of communication
Classical and bureaucratic (i.e., Weber's theory of bureaucracy, Taylor's theory of scientific management)	Mechanistic: specialisation, stability, predictable, controllable and reproducible	Top-down, formal chain of command, formalised prescription of responsibility, describing appropriate patterns of communication activity within a bounded system
Human relations (i.e., Maslow's hierarchy of needs theory, Herzberg's motivation-hygiene theory, Mayo et al.'s Hawthorne studies)	Quality of human relationships, affiliation and social interaction	Informal, mostly horizontal communication
Human resources (management theories such as Likert's system IV, Ouchi's theory Z, TQM)	Maximisation of both organisation productivity and employee satisfaction through the intelligent use of human resources	Variety forms of communication from task-related, formal communication to informal, team- based interaction

(Source: Based on Miller, 2003)

Based on Miller (2003), it is observed that the first and second type of organisation reflect the key characteristics of coordination from structure-based and human-based respectively, whereas the third type reflects both the structure and human-based. Given this, the human resource model suggests a variety of coordination activities.

This generalised view on the type of organisation thus suggests that organisations associated with the human resource type, including TQM organisations, are likely to be a potential setting for investigating the complexity of coordination phenomenon.

2.2.2.2 Meaning and Action

This view emphasises the role of communication as a medium for generating meaning and organised action. However, while scholars generally accept the intertwined relationship between meaning and action, they differ in their views on the extent to which an amount of shared meaning is needed to result in collective action. One group of scholars argued that collective action occurs in a high degree of shared meaning (e.g., Pfeffer, 1981; Smircich, 1983c; Smircich & Morgan, 1982) whereas another group of scholars (e.g., Eisenberg, 1984; Weick, 1979) saw a minimum degree of shared meaning is sufficient for collective action. However, in one study, Donnellon, Gray and Bougon (1986) provided empirical evidence to support the latter view.

Donnellon, Gray and Bougon (1986) found that collective action can occur through a repertoire of shared communication mechanisms, despite differences of interpretation among organisational members. According to them,

If achieving shared meaning is not possible, influential members can still rely on their repertoire of shared communication mechanisms to create “equifinal meaning” consistent with their desired course for collective action (p. 53)

According to them, “equifinal meaning” refers to interpretations that are dissimilar but that have similar behaviour implications—that is organisation members may have different reasons for understanding the action and different interpretations of the action’s potential outcomes, but they nonetheless act in an organised manner (Donnellon et al., 1986, p. 44).

The view of meaning and action is often explained through cognition theory. Cognition is an individual interpretation scheme which Ranson, Hinings and Greenwood (1980) saw as the personal and organisational maps that staff members use to help them organise and make sense of their workplace experiences. Geertz (1973) saw these interpretations serve to guide actions. Similarly, Eisenberg and Riley (2001) also noted that “one must investigate the cognitive frames that facilitate coordinated action” (p. 305).

The process of interpretation within organisation is described by Weick (1995) as “sensemaking”. The sensemaking process facilitates organisational members’ focusing on salient cues, and developing perceptions and understanding of how their organisation works and what are appropriate behaviour and actions (Weick, 1995). Once information flows into an organisation’s cognitive system, it is interpreted and given meaning and is often used as the basis on which organisational actions are built (Sutcliffe, 2001). Given this, several scholars (Daft & Weick, 1984) often highlight the important role of organisation’s top decision makers which is believed to affect an organisation’s cognitive system, which in turn affects employees’ sensemaking processes. Gioia and Chittipeddi (1991) called the process in which someone attempts to influence others’ sensemaking and meaning construction toward a preferred direction or reality as “sensegiving”.

The literature reviewed in this section thus suggests that the communication capability (sensegiving) of the influential person in a company can affect the organisation’s sensemaking process, which in turn, facilitates coordination through shared meaning. This view on cognition, communication, and coordination may provide a theoretical explanation for some characteristics of coordination such as “shared goals” and “mutual knowledge” which are often addressed in coordination literature without a theoretical explanation.

2.2.2.3 Discursive Control

This aspect suggests that coordination can be facilitated through the use of language as a control device. Language or communication is seen as an implicit mode of control, called “discursive control” (Barker, 1993) which is observed to share similarity to the notion of “discursive coordination” (Minssen, 2005). In their studies on organisational change, Czarniawska-Joerges and Joerges (1988) proposed that language or linguistic artifacts are used as control tools and instruments of change. They enable management to promote new managerial philosophies and values, or to construct meaning and reality within organisation.

The study of Czarniawska-Joerges and Joerges (1988) focused on organisational talk as the use of verbal symbols in an attempt to structure meaning and coordinated action. In other word, talk is a kind of social action that gives a social order or social

coordination because the management can achieve coordinated action through “the use of language in intentional acts of communication” (p.173). This linguistic artefact enables leadership to manage meaning by “explaining, colouring and familiarising, as opposed to the traditional control methods of commanding and punishment” (p. 188).

Czarniawska-Joerges and Joerges’ idea is similar to the idea of “framing”. Frames are language-created windows and lenses on organisational experience that focus workers’ perception and understanding, and managers can use framing as a tool to help workers order experience, shape understanding, and help them decide what to think and do (Bolman & Deal, 1997). A frame is defined as “a quality of communication that causes others to accept one meaning over another” (Fairhurst & Sarr, 1996, xi). Hence, framing involves communications that shape the general perspective upon which information is presented and interpreted. Fairhurst and Sarr argued that framing is an art whereby leaders manage meaning and socially construct reality for themselves and their followers.

Several scholars suggest that the communicative practices associated with many high involvement innovation situations merely change the way control is enacted rather than actually freeing workers from the “iron cage of bureaucracy” (Barker, 1993). In contrast to the obvious control mechanisms of traditional bureaucracies (e.g., rules, work processes, and authoritarian line of command), participation may unobtrusively control employees’ behaviour by controlling their decisions, that is through “concertive control” (Tompkins & Cheney, 1985). For example, the degree to which employees participate in networks that collaboratively develop norms and rules that have internalised organisational values, the more likely they will make decisions that conform to these values (Cheney, 1983).

Strong identification with team members, peer pressure, personal investment in the rules that have been developed, and consensual decision making all combine to make this form of control very powerful. Barker (1993) concluded in his study of a manufacturing company, that the high levels of employee identification, the high degree of consensus about values, and the personal connections that develop from working on a team create a powerful system of “concertive control” in which workers

control and monitor themselves to an even greater extent than found in a typical bureaucratic organisation.

2.2.2.4 Communication Climate: Leader-Member Interactions

The communication climate can be viewed multi-dimensionally depending on a researchers' ways of categorising based on organisational members' perception of such factors as: the supportiveness of superior-subordinate relations; quality of accuracy of downward communication; opportunities and efficacy of upward communication; communication satisfaction; and organisation commitment (Poole & McPhee, 1983). Tukiainen (2001) proposed three dimensions of (1) superior communication and ways of conduct (i.e., the ways to conduct communication; organisational structure and the rules of communication); (2) horizontal face-to-face communication (i.e., peer communication, the general willingness to communicate); and (3) functioning of the communication process (i.e., general functioning of communication flow, quality and quantity of communication flow).

However, several communication scholars observed the influential role of leaders or managers in nurturing certain working atmospheres that encourage members toward goal accomplishment (e.g., Bordow & More, 1991; Jablin, 1979). Jack Gibb (1961), in particular, argued that managers' communication behavioural characteristics contributed to "defensive" or "supportive" communication climate. Within each type, Gibb (1961) listed six categories of behavioral characteristics, according to table 2.2.

Table 2.2: Gibb's (1961) Defensive and Supportive Communication Climate

Defensive Communication Climate	Supportive Communication Climate
1. Evaluation	1. Description
2. Control oriented	2. Problem oriented
3. Strategy	3. Spontaneity
4. Neutrality	4. Empathy
5. Superiority	5. Equality
6. Certainty	6. Provisionalism

Source: Gibb (1961)

Gibb's description of each category of behavioral characteristics is as follows. The first category, *evaluation* and *description*, is based on evaluative and descriptive communication. Evaluative communication occurs when individuals feel threatened

or judged, regardless of positive or negative comments. In contrast, descriptive communication occurs when individuals are free to give information rather than conclusion. Descriptive communication is seen to reflect the idea of “openness” in message sending and receiving with sub-ordinates and peers (Jablin, 1979, p. 1204) or encouraging, or at least allowing, frank expressions of views and the willingness to listen to bad news (Redding, 1972, p.330).

The second category, *control oriented* and *problem oriented*, is related to communication processes in managing issues or problems within an organisation—whether solutions are imposed on or, being sought from organisational members. Managers who are control-oriented may use various methods of control from explicit communication such as legalistic insistence on details, restrictive regulations and policies to implicit communication such as conformity norms, gestures, and facial expression. However, managers who are problem-oriented desire to collaborate with subordinates in defining a mutual problem and in seeking its solution. Gibb’s problem-orientation is found to be associated with other elements of communication climate such as involvement, peer interaction, frequency of collaboration, perception of usefulness, freedom of communication and participative decision making (Redding 1972; Stohl, 1995). If taking a view from communication direction, it involves opportunities for and the degree of influence of upward communication (Jablin, 1979), and horizontal and informal communication and peer communication (Tukiainen, 2001).

In the third category, *strategy* and *spontaneity*, Gibb (1961) viewed strategy communication as creating a defensive communication climate; it occurs when the listener perceives messages sent are strategic messages, gimmicks and tricks to fool or to involve people for some reasons that may be beneficial only to the sender. In contrast, behavior which appears to be spontaneous and free of deception is defense reductive (Gibb, 1961, p.146). Gibb’s “spontaneity” occurs when a communicator is being straightforward and honest. In addition to Gibb’s spontaneity, Apker, Ford, and Fox (2003) found that supportive communication is created by trust, respect and openness.

In the fourth category, *neutrality* and *empathy*, Gibb viewed neutrality in message as indicating a lack of interest or concern is likely to create a defensive communication

while communication, that conveys empathy for the feelings and respect for the worth of the listener through identifying himself with the listener's problems as well as sharing his feeling is supportive and defense reductive (Gibb, 1961, p. 147). The empathetic behaviour can also be associated with other dimensions of communication climate like warmth, intimacy and relational openness (Redding, 1972; Tukiainen, 2001).

As for the fifth category of *superiority* and *equality*, Gibb (1961, p. 147) noted that a communicator who shows their superiority will not be willing to enter into a shared problem-solving relationship, does not desire feedback and does not require help. That person is also likely to try to reduce the power, the status or the worth of the receiver. In contrast, a communicator who shows their equality characteristics will be receptive and willing to enter into participative planning with mutual trust and respect. Based on Gibb's view, communicating with superiority may cause inferiority or inadequacy of the listener, which in turn, discourages the listener from discussion and/or interaction. This communication category is related to other communication climate dimensions of information adequacy, information flow, openness and candor, opportunities for upward communication, reliability of information, personal feedback, willingness to communicate, participative decision making and interpersonal relationship (Bordow & More, 1991; Falcione, Sussman, & Herden, 1987; Redding, 1972; Stohl, 1995; Tukiainen, 2001).

As for the last category, *certainty* and *provisionalism*, Gibb (1961: 148) explained that defensive behavior occurs when a communicator seems to know the answer, to require no additional data, and to regard themselves as teacher rather than co-workers. This could mean that this person believes his or her decision is right and definite. Gibb (1961) observed this kind of behavior is often associated with an attempt to exercise power. This is contrary to speakers with a provisionalism communication character who appear to be taking provisional attitudes, to be investigating issues rather than taking sides on them, to be problem solving rather than debating, and to be willing to experiment and explore new things (Gibb, 1961, p.148). This latter characteristic demonstrates speakers give their point of view with an open attitude. Suspending judgment and examining facts as they are presented about situations, can establish a supportive climate (Bohm, 1996).

A similar idea to Gibb's work is found in the concept of Leader-Member Exchange (LMX) and cooperative communication. Lee (1997) explored effects of differential quality of leader-member exchange on cooperative communication among members of work groups. The findings suggest that the nature of an individual's own exchange with his or her leader have a significant impact on perceived use of cooperative communication among co-workers. In other words, Lee found the quality of vertical communication and interaction, between leader and members, enhanced horizontal relationships as well as facilitated horizontal communication.

Other studies on LMX also found work characteristics associated with high level of leader-member information exchange such as mutual support, trust, sharing ideas and resources; showing concern and interest in what others want to accomplish; open to each other's needs, and consulting and discussing issues to reach mutually satisfying agreements (e.g., Fairhurst & Chandler, 1989; Lee & Jablin, 1995). In contrast, in the Milliken, Morrison, and Hewlin (2003) study, the researchers found that one of the reasons why employees are sometimes silent about their concerns is the hierarchical, formal relationship between subordinates and their supervisor. They found upward communication is affected not only by characteristics of the communicator, the message, and the organisational context, but more importantly, by characteristics of the supervisor-subordinate relationship. They observed that before deciding whether to speak up about a particular issue, employees develop a cognitive map of the organisation's communication norms, "a map of what one can and cannot say, and of what may happen as a result of different forms of communication" (Milliken et al., 2003, p.1456). They also found that most of the time, employees remain silent because they believe that even if they spoke up, it would make no difference.

2.2.2.5 Conversation and Workplace Relationships

Everyday workplace conversation is found to play an important role in maintaining communication attitudes and practices as well as sustaining relationships between staff members and this may be supportive of relational coordination (Gittell, 2000). In the past decade, research focusing on discourse analysis emphasising the role of conversation in a variety of setting including the work place has increased (Ford & Ford, 1994; Cooren, 2004). This research shows that everyday conversation has a powerful influence on action. For example, Brown and Duguid (2002) described how

Xerox service technicians' unofficial daily breakfast get-togethers helped each other solve difficult repair problems not treated in their manuals. Not only did the chat, talk, and stories during these breakfasts increase technicians' individual and collective knowledge far beyond that provided in the technicians' repair manuals, but such conversation also improved their awareness of each other, helped establish their identities as skilled technicians, and perhaps most important, created new avenues of interaction fundamentally different from that provided by Xerox's organisational structure.

Supportive communication enhances interpersonal relationships in the workplace because it serves both informational functions in clarifying role expectations and reducing uncertainty, and emotional functions in promoting discussion of feelings and building self-esteem (Podolny & Baron, 1997). Interpersonal relationships in the workplace are found to be central to the notion of "social capital" (Burt, 1992) which can be thought of as resources (e.g., trust and goodwill) embedded in a social structure (Adler & Kwon, 2002). It stems not from personal characteristics or assets, but from ties to others, and is valuable because it can be accessed and/or mobilised to facilitate action (Milliken et al., 2003). An actor within an organisation can have more or less social capital at his or her disposal as a function of the social network of relationships tying that actor to others (Adler & Kwon, 2002). Research has shown that social capital plays an important role in facilitating coordinated action, particularly in contexts where people need the trust and cooperation of others to achieve their objectives (Burt, 1992; Podolny & Baron, 1997).

2.2.2.6 Organisational and National Culture

The aspect of organisational culture can be seen as an umbrella aspect of all the other aspects, given that the culture has significant influence on organisational values which affect patterns of thinking, behaviour, communication and interaction within an organisation. This aspect thus assists with the understanding of coordination through the view that communication is a tool for an enculturation process which creates shared meaning (Pacanowsky & O'Donnell-Trujillo, 1983; Weick, 1995), offers guidelines for appropriate action (Minssen, 2005), and encourages people to act in ways that have mutual relevance (Smircich & Stubbart, 1985).

A communication approach to culture requires a consideration of “the way individual make sense of their world through their communicative behaviours” (Putnam, 1983 p.31). Putnam sees culture as a social reality which is a symbolic process “created through ongoing actions and intersubjective meanings attributed to those actions” (p. 44). In other words, communication scholars see culture as socially created through to communicative performance of members within an organisation.

Smircich (1983a) asserted that management can influence the construction of culture which encourages collective action by attempting to:

...define interpretations and meanings that can become widely understood and shared by organisation members so that actions are guided by a common definition of the situation. Those with power are able to influence the course of organisational development through control over valued resources and through use of symbols by which organisation members mediate their experience (p. 348).

It is presumed that employees may be cooperative and act responsively to the management’s interpretations, given it is perceived as a part of being a good employee. However, Mumby (1989) warned that the social construction of culture through communication also involves a struggle over dominant interpretations of the myriad of discourses that constitute a culture. Nevertheless, Mumby (1989) admitted that certain dominant groups such as managers and corporate owners are often able to influence the interpretation and meaning-formation within an organisation.

The influence or the drive behind management’s attempt to institutionalise certain values and beliefs within an organisation is found to be addressed within the context of “ideology”. Ideology refers to the body of ideas that reflects the social needs or worldview of an individual, group, or culture (Alvesson, 1993). Through the use of “ideological control” (Alvesson, 1993), management within an organisation may persuade workers to internalise commitment to, for instance, producing high quality service, or to increase organisation profits.

Nevertheless, management’s attempt to internalise their “own particular world-view or ideology” (Mumby, 1989, p. 24) may have a different result because resistant interpretations are always possible (Mumby, 1989). This is the reason why Martin (2002) argued that organisational culture should be viewed from three perspectives:

“integration” (some interpretations are shared by all members), “differentiation” (different interpretations exist among groups, creating subcultures that overlap and nest in terms of harmony, independence or conflict), and “fragmentation” (individuals and groups may interpret with ambiguity, with irony and paradox, and irreconcilable tension).

Besides ideology, social environments such as national culture may enhance or impede the management’s interpretation of organisation values. As Gouran (1997) notes that the cultural background of group members is an important antecedent variable. Research reveals that individuals from collectivistic cultural traditions are more cooperative than individuals from individualistic culture traditions and that groups composed of homogenous members representing collectivistic culture have more positive assessments of group processes and outcomes than collectivistic members in heterogenous groups (Cox, Lobel, & McLeod, 1992; Thomas, Ravlin, & Wallace, 1996).

Within a “Thai cultural context”, there are mixed views whether Thai has a collective or individualistic culture. Triandis (1995) argued that Thai have a loose culture, or an individualistic culture because of the ability to absorb diverse cultural, religious, geographical and climate influences. Thais have demonstrated the ability to adapt, adjust to and tolerate new or foreign influences (Mole, 1973; Muscat, 1990). Ketudat (1990) found Thai people tend to possess some unique qualities of being assimilated towards diversities, with special features focusing on human relationships.

On the other hand, scholars led by Hofstede (2001) argued that Thai is a collective culture which is group and socially oriented. Generally, collectivism refers to emotional dependence on family, kinship, structure, organisation and the social system. Highly collectivist cultures emphasise social interdependence, connectedness and mutual deference or compromise as dominant values (Flynn, 2005). In contrast, individualism is exemplified in those cultures that emphasise independence and autonomy in choice and action, and social assertiveness (Triandis, 1989).

Nevertheless, in a study by a Thai psychologist, Komin (1990), Thai culture was said to consist of both individualism and collectivism. As she concluded, “Thai social

system is first and foremost a society where individualism and interpersonal relationships are of utmost important” (p. 691). Based on the result of her empirical study conducted among 2,149 Thais, Komin (1990) identified nine orientations that reflect Thai characteristics and behaviours.

Table 2.3: Orientations of Thai Behaviour

1.	ego
2.	grateful relationship
3.	smooth interpersonal relationship
4.	flexibility and adjustment
5.	religion-psychical
6.	education and competence
7.	interdependence
8.	fun-pleasure
9.	achievement-task

Source: Komin, 1990

Some of Komin’s orientations such as “smooth interpersonal relationship” and “interdependence” can help nurturing coordination. Nevertheless, these orientations are associated with “non-assertiveness” attitudes and behaviours such as face-saving, criticism-avoidance and *Kreng Jai* (deference and consideration). Some writers saw the *Kreng Jai* attitude, which is to be considerate, to feel reluctant to impose upon another person, to take another person’s feelings into account and to be careful not to cause discomfort or inconvenience to another person as a distinctive attitude of Thais (Klausner, 1987, Sriussadaporn-Charoenngam & Jablin, 1999). While these attitudes and behaviours can be helpful for coordination from a harmonised, interpersonal relationship perspective, they can impede coordination from a communication perspective, given their non-assertiveness attitudes and behaviours.

2.2.3 The Research Opportunity

This review of the organisational communication literature suggests the possibility of investigating coordination more holistically given the identified six aspects from communication perspective. Through the lens of organisational communication, coordination can be found in a number of ways. Besides the aspect of organisation form and communication structure which reflects the traditional, structure-based coordination, coordination is found in the *cognitive-based* (meaning and action aspect), *discursive based* (discursive control aspect and conversation and workplace relationships aspect), *interaction based* (communication climate: leader and member

interaction aspect) and *cultural based* (organisational and national culture aspect). These dimensions of coordination suggest an opportunity for the researcher to observe coordination outside its dominant view of structured-based.

2.3 Total Quality Management, Coordination and Communication:

Context of the Study's Investigation

While the literature review in the first and second section informs the established linkage between coordination and communication, the review in this section specifically focuses on the existing literature and empirical studies within the selected context for the study's investigation, Total Quality Management (TQM). This section begins with a brief overview of TQM and its relation to coordination, prior to a survey of TQM literature in relation to organisational communication. Some research problems and opportunities for choosing TQM as a context for investigation on coordination and communication are also identified in this section. The review of this section also identifies some research problems and opportunities for choosing TQM as a context of investigation of the link between coordination and communication.

2.3.1 TQM: Overview and Its Relation to Coordination

James (1996) described the emergence of TQM as evolving from the development of the previous three eras of quality management; starting from the first era of product quality control, the second era of process control, and the third era of the development of system control such as ISO 9000. TQM is the fourth era which James described as a "philosophy" that:

seeks to gain organisation-wide commitment, through participation, to manage quality effectively so that errors are minimized and customers are consistently satisfied (1996, p. 9).

Similarly, Hill (1991) saw TQM as a philosophy of management which institutionalises planned and continuous business improvement through employee participation and involvement with the purpose of satisfying the customer in a market place. This study adopts the view of TQM as a philosophy. This is because it allows a more open-minded approach toward TQM and thus can avoid unnecessary debates over issues such as what is TQM. Even among key writers such as Feigenbaum (1961), Crosby (1979), Deming (1986), and Juran (1991), there is confusion as to

what TQM means when they discuss TQM (Wilkinson, Marchington, & Goodman, 1992). In a case study of TQM in service firms, Kelemen (2000) observed that the language of TQM is ambiguous and that there is no clear set of criteria for deciding what counts as TQM practices and what does not.

Ehigie and McAndrew (2005) support the view of TQM as a philosophy, or a set of values or a way to reorganise business. By viewing TQM this way, it means TQM can be adapted to suit a specific organisational context and is in hands of managers to interpret and implement the tenants of TQM according to how they think the values and philosophies can be accomplished. Similarly, in a comprehensive examination of TQM in relation to the “mechanistic”, “organismic”, and “cultural” models of organisations, Spencer (1994) observed that “in practice TQM does not describe an objective reality but instead depicts a somewhat amorphous philosophy” (p.468). This would mean that the adoption and implementation of TQM can appear in either top-down approach as advocated in the mechanistic model or in a bottom-up approach as advocated in the organismic model, as Spencer (1994) noted, depending on the choice of management.

If TQM is seen as a management’s philosophy, then what is its relation to “coordination?” This study considers that the value of TQM to coordination could result from the idea of systematic (Anderson, Rungtusanatham, & Schroeder, 1994) or, organisation-wide underpinning TQM philosophy. Although different strategic implementations are offered by TQM founders (e.g., Crosby, 1979; Ishikawa, 1985; Deming, 1986), academic, and business writers (James, 1996; Oakland, 2004), they all seem to share the idea of an “organisation-wide” approach to TQM.

For instance, Ishikawa’s (1985) “company-wide quality control” demands that all the separate parts of a company must work together. Similarly, Anderson et al. (1994) observed that Deming’s system thinking is the pursuit of internal and external cooperation. Deming (1992) takes a systemic view of organisations and emphasises the structural links between its components. His view reflects the notion of coordination, as he noted:

A system is a network of functions or activities within an organization that work together for the aim of organization (p. 26).

TQM academic and business writers commonly share the view that the organisation will benefit from working together cooperatively in the pursuit of quality and customer satisfaction. In his recent work, Oakland (2004) strongly argued that TQM requires an effective coordination of all components within an organisation. He provides a system view of TQM implementation which requires the three hard management necessities: “planning” (right policies and strategies), “processes” (supporting management systems and improvement tools, such as statistical process control) and “people” (with the right knowledge, skills and training).

Despite the differences among approaches and strategies to TQM implementation, there are some commonalities that reflect the fundamental philosophy of TQM (Dean & Bowen, 1994; Spencer, 1994) including *common vision, leadership, continuous improvement, problem solving, process focus, customer focus, teamwork* and *empowerment*. For the purpose of this study, these values or principles of TQM are reviewed relating to their relation to coordination.

Common vision. In TQM, common vision, a shared vision, or shared goals among employees and management are critical for organisational success (Anderson et al., 1995; Deming, 1986; Hackman & Wageman, 1995). Detert, Schroeder and Mauriel (2000) saw that a shared vision and shared goals refers to a belief in the power of coordinated action. According to them, a shared vision and shared goals “require that all staff members know and understand the organisation’s vision and are willing to align their actions accordingly, even if they have to sacrifice some autonomy for the sake of organisation-wide goals” (p. 857).

Leadership. Research on TQM has consistently found strong link between leadership and success or failure in TQM implementation. The insistence that leadership is the key element to achieving TQM has been emphasised by TQM advocates (Deming, 1986; Juran, 1991; Oakland, 1997, 2004) and academic scholars (Dean & Bowen, 1994; Lawler, 1994). Several studies shared similar result of the significance of leadership in achieving TQM (Savolainen, 2000) and of the absence of leadership in failed TQM attempts (Beer & Nohria, 2000; Young & Wilkinson, 1999).

Interestingly, while the term leadership itself may not be restricted only to people at the top-management level, the majority of the literature reviewed usually related “leadership” to senior management (Beer, 2003). This could be due to the fact that senior managers have power in institutionalising values, organising key organisational strategies and allocating resources and technical arrangement.

Besides their power and resources, some writers observed the “transformative” characteristic of leaders in relation to TQM success (Anderson et al., 1994; Dean & Bowen, 1994; Waldman, 1994). Transformative leadership (Bass, 1985; Burns, 1978) is characterised as going beyond exchanging inducement for performance (as in transactional leadership) by “developing, intellectually stimulating and inspiring followers to move beyond their self-interest to pursue a larger collective purpose or mission” (Howell & Avolio, 1993, p. 891).

Some communication scholars, however, argue for the ability of leaders to manage meaning in such a way that individuals orient themselves to the achievement of TQM. In other words, if leaders want to succeed in their TQM attempts they may need to improve their rhetorical skills (Smircich & Morgan, 1982). Finally, some scholars observe that the success of TQM derives from the role of leadership in framing and shaping “cognitive” references as the context of action in such a way that the followers are able to use the meaning thus created as a point of reference for their own actions and understanding of the situation (Gioia, Thomas, Clark, & Chittipeddi, 1994; Reger, Gustafson, Demarie, & Mullane, 1994).

Based on this literature, the relationship between leadership and coordination can be seen in their power and ability in facilitating coordinated action, through the use of power and resource, transformational characteristics, rhetorical skills, and cognitive approach. In addition to this, coordination is found to be dependent on the preferred management approach. Spencer (1994) observed different modes of coordination is used by management in different models of organisation—that is “visible form” of control in the mechanistic model, “creating vision” in the organismic model and, “establishing values” in the cultural model.

Continuous improvement. This value is generally presented as the key to customer satisfaction (Anderson et al., 1994; Deming, 1986) and is generally understood to comprise both technical processes and human resource considerations such as the use of teamwork approach and training and educations. Bessant, Caffyn, Gilbert, Harding and Webb (1994) saw continuous improvement as a company-wide process of focused and continuous incremental innovation sustained over a long period of time. Continuous improvement thus can be seen as the core value of TQM as it encompasses others values, particularly process focus, problem-solving, empowerment and teamwork. Dean and Bowen (1994) saw continuous improvement consists of “practices” and “technique”. Practices including process analysis, problem solving and the use of quality circles (Plan, Do, Check, Act), whereas techniques are analysis techniques such as flow charts, Pareto analysis, statistical process control and fishbone diagram. In this regard, continuous improvement can be seen as a *driving value* for coordination, given coordination appears to be facilitated in various forms including technical, administrative and human resources.

Problem solving. Problem solving is related to the idea of a team approach to identify problems and solution to the problem. The use of Deming’s (1986) quality cycle of Plan, Do, Check, Act is likely to promote coordination through the process of information exchange between team members and the coordinated data and information for decision making and strategic action. The repetitive applications of the sequence Plan, Do, Check, Act (Troutt, Ponce de Leo, & Bateman, 1995) is likely to provide a coordinated platform for sharing information and coordinate action plans and follow up.

Process focus. Process focus is a result of the systematic approach. Waldman (1994) saw process endogenous to the system as conceived in terms of a wide range of interpersonal, organisational and technical factors and he observed that, for Deming, systematic factors determined the mean level of performance among individuals. Ashforth (1992) noted that process can be seen as a network of interacting units and processes intended to realise some purpose. In this way, the idea of process can be seen to reflect the structure-based coordination. In their conceptual work, Lemak and Reed (2000) applied Thompson’s typology of pooled, sequential and reciprocal

interdependence into various types of service firms. They concluded that TQM process can act as a coordinating mechanism.

Customer focus. Anderson et al. (1994) observed that the issue of customer satisfaction is central in any theory of quality management because:

...the very definition, and consequently, the measurement of customer satisfaction has often been based on a customer's perception of the quality of products and services (p. 491).

Dean and Bowen (1994) identified three practices in exemplifying customer satisfaction of: (1) direct contact between product and/or service providers and their customers; (2) the collection of specific information about customer requirements; and (3) the inclusion of information provided by customers in the design and delivery of product and service. In addition, Reger et al. (1994) argued that direct contact between product or service providers and their customer is:

...likely to make members aware of the shortcoming of the existing organization, and customers' communication about their ideals for the organization may prompt members to reassess their views (p. 575).

It is seen that customer focus serves as a driving value for coordination similar to continuous improvement, given customer satisfaction provides both the impetus for instituting and the standard of evaluating total quality initiatives.

Teamwork. The use of teamwork is seen as the basis for continuous improvement and customer satisfaction (Dean & Bowen, 1994). TQM literature consistently identifies teams as the context and teamwork as the necessary requirement for effective problem solving and decision making (Hackman & Wageman, 1995). Teamwork is often discussed in TQM literature as a form of cross-functional coordination (Spencer, 1994) and that this form of coordination is seen to promote both horizontal and vertical communication. Hackman and Wageman (1995) put it:

The cross-functional quality teams that are among the hallmarks of TQM organizations stack the cards in favor of learning by the simple fact that they are cross-functional; individual members are exposed to more, and more diverse, point of view than would be the case if they worked mostly by themselves or in within-function units (p. 331).

As discussed previously that the nature of teamwork reflects both reciprocal communication and relationships, teamwork is thus seen as an effective mode of

coordination. That TQM promotes the use of teamwork means teamwork may increase coordination effectiveness.

Empowerment. Empowerment is a leadership attitude and way of thinking that promotes participation, autonomy and commitment among employees which differs from the tradition power and control concept of management (Scarnati & Scarnati, 2002). However, empowerment is among the more controversial components of TQM philosophy. Waldman (1994) for example, noted that “some people may perform better on a traditional assembly-line process with autocratic management, whereas others respond better to team-oriented assembly methods of high involvement of management” (p. 517). Thus the appeal and benefits of empowerment cannot be assumed to be consistent across contexts. Nonetheless, there is both a theoretical basis and some empirical evidence for the claim that worker empowerment increases motivation and job satisfaction (Anderson et al., 1994; Dean & Bowen, 1994).

Hackman and Wageman (1995), however, argued that “the distribution of authority in an organization typically does not change much when TQM is implemented” and observed that there is a tendency that management engages in “pseudo-participation” that “members are invited to join in discussions about decisions that already have been made or that will be made by someone else” (p. 333). While Hackman and Wageman observed empowerment as a form of participation and involvement, some writers discussed empowerment in other forms such as training and education (Spencer, 1994; Tonnessen, 2005).

2.3.2 The Research Problem and Opportunity: the Unclear Link between TQM and Coordination

The review of TQM literature has so far examined the relationship between TQM and coordination. It is observed that, despite the mainstream literature explicitly or implicitly emphasising coordination, interdependence and cooperation as essentials to TQM (Oakland, 1997, 2004), little empirical evidence regarding the link between TQM and coordination has so far been provided. More importantly, the empirical data in fact documents difficulties in achieving coordination in TQM implementation.

Rago (1996) provided case studies of TQM implementation in a government agency and concludes that leaders struggle with two particular tasks, communication and coordination. Similarly, Jenni and Mauriel (2004) conducted a longitudinal study of 49 schools purporting to practice and apply TQM. They used nine TQM values (including shared vision, continuous improvement and stakeholder focus) and found the value of “cooperation and collaboration” received the widest gap between what the respondents thought “should be” happening and what they reported “was” happening. This finding suggests the idea of TQM’s coordination is more rhetoric, than reality.

In his conceptual paper, Dervitsiotis (2002) argued that two significant causes for disappointing TQM results have been lack of framing problems in systematic terms and the poor coordination resulting from inefficient communication patterns. More specifically, he argued that human communication flow is often neglected in implementing TQM and proposed for the idea of “conversation for action” to increase effective coordination. A similar view is also found in a paper of Baim and Dimperio (2001) who asserted that “TQM is an approach that guarantees absolute failure if participants fail to communicate effectively or to solve problems in a collaborative way” (p.51).

One of the key reasons that the link between TQM and coordination is still unclear is likely due to the fact that TQM literature is still lacking in empirical evidence from organisations that have successfully implemented TQM. More studies on successful TQM cases could provide a better understanding of the contribution of TQM to coordination. More importantly, there is also an opportunity to obtain insightful understanding of coordination from a communication perspective, given a link between coordination and communication is also established in TQM literature. To assist with the understanding of this established link, the existing literature relating to TQM and communication is reviewed in the following part.

2.3.3 Communication within TQM Organisations

The role of communication as an integral component in TQM implementation is widely acknowledged among TQM authors (e.g., Beer, 2003; James, 1996; Oakland, 1997, 2004) and that it is observed several authors often emphasised communication

within the context of senior managers. It is observed that in practitioner-oriented TQM literature, managers are suggested to build open, independent, trusting, superior-subordinate relationships (Oakland, 2004), to do more listening than talking (Schmidt & Finnigan, 1993), and to share useful information and allow subordinate meaningful influence over their work-related decisions (Saskin & Kiser, 1993).

Oakland (2004), for instance, asserted that successful TQM implementation requires direct and clear communication from the top management:

The key medium for motivating the employees and gaining their commitment to quality is face-to-face communication and visible management commitment (p.420).

Based on a review of previous research, Beer (2003) strongly called for the senior management team to create “effective organisation-wide dialogue” in order to obtain employees’ commitment to TQM. He also noted that poor vertical communication impeded the quality initiatives, as he put:

Without honest vertical communication the senior team cannot discover the leadership and management problems that are blocking use of technical methods like statistical process control (p. 630).

While communication is widely recognised as an integral component of TQM implementation, only a small body of communication specific research exists in TQM literature (Lewis, 1999). More importantly, Allen and Brady (1997) observed the lack of communication studies within TQM organisations; according to them:

Although numerous empirical studies have explored many of the important aspects of communication discussed in the TQM literature, few empirical studies actually investigating communication within a TQM setting exist (p. 317).

In their study, Allen and Brady (1997) investigated whether TQM resulted in organisational commitment, perceived organisational support and intra-organisational communication. The finding suggested that organisational commitment and perceived organisational support were significantly higher in the organisations implementing TQM. They found that employees in the organisations implementing TQM showed more positive employee-top management, co-worker communication relationships, as well as more quality information from top management (p.316).

In a study within a manufacturing enterprise implementing TQM, Shohl (1984) found a difference in communication between quality circle and non-quality circle groups. She pointed out that participants in a quality circle program knew and talked to more individuals throughout the plant and developed a broad understanding of the organisational operations than did non-circle workers. In a multiple case study design, Lewis (2000) investigated the implementation of quality programs in an education department, a hospital, a university and a messaging technology company. Her findings suggest that implementers struggle with creating and communicating vision, sensemaking and feedback, establishing legitimacy and communicating about goal achievement.

Fairhurst and Wendt (1993) suggested implementing a team-based system prior to or concurrently with TQM to ensure that the communication relationships within and between teams are characterised by the openness, empathy and quality of participation prescribed by authors describing TQM philosophy. Fairhurst (1993) conducted a case study of a TQM organisation. Using discourse analysis and routine work conversations between leaders and members, she found five framing devices: communicated predicaments, possible futures, jargon and vision themes, positive spin and agenda setting contributed to the success or failure in communicating vision. According to Fairhurst (1993):

When the framing devices were effectively used, leaders and members served as resources for one another in supplying information about choice points in predicaments and their resolution in possible futures (p. 365).

Fairhurst (1993) also observed that the use of framing devices encouraged middle-and lower-level managers to mobilise their support for the TQM vision, adapt TQM principles to fit workplace conditions, and deal with any conflicts occurring when TQM challenges established rules and practices. Several researchers highlight “framing” and language as a potential area to pursue in change management research as a result of their studies (Ford & Ford, 1995; Gioia et al., 1994). Ford and Ford (1995) posited that organisational change is a product of organisational conversations. The challenge for change agents is to take a role in “authoring” the conversations and intentionally shifting the conversation to create new organisations (Ford & Ford,

1995). Thus the conversations within organisations both shape the change process and are the way that reality is constructed within organisations.

Zorn, Page and Cheney (2000) present a study of three different perspectives of change communication within a business services department of a large local government department in New Zealand. They found that within the longitudinal study, managerial discourse is both “pervasive and persuasive” (p. 555). They highlight the “concertive control” that the active participation within dialogic change communication processes creates, and caution against the camouflage of control as “non control”, or what might be considered “pseudo dialogic” practices.

Some research scholars specifically pay attention to the rhetoric or reality of TQM by arguing the role of managers in implementing TQM is merely to engage in the language game and that TQM serves mostly a symbolic purpose (Pfeffer, 1981). Zbaracki (1998) attempts to contrast “rhetorical TQM” with “technical TQM”, arguing the first as obstruction to the second. Managers will use the rhetorical TQM to gain legitimacy without affecting activities at the technical core of the organisation (Meyer and Rowen, 1977). Westphal, Gulati and Shortell (1997) discuss the role of “communication ties” in the institutional forces that encourage conformity in TQM adoption.

Although the relationship between TQM and communication has more empirical support than the relationship between TQM and coordination, this evidence is still fragmentary in considering the effect of TQM on communication, particularly at the organisation-wide level. Given this, a study of communication within an organisation that has successfully implemented TQM is likely to provide a more comprehensive understanding of the relationship between TQM and communication.

2.4 Summary

This chapter has reviewed some of the literature on coordination, organisational communication and TQM. Based from the review of coordination and organisational communication literature, it is established that there is both theoretical and empirical

evidence that supports an equivalency linkage between coordination and communication. More importantly, the review of the organisational communication literature also suggests a variety of forms that coordination may take. The review of the two literatures thus highlights a potential that the existing understanding of coordination can be enriched through the investigation from communication perspective, rather than investigating coordination within its own perspective in which the existing literature tends to offer a limited view on how coordination can be achieved at a company-wide level, from the structure-based dimension.

The review of organisational communication literature also provides additional evidence of the human relationship type of organisation type likely to be associated with a more complex form of communication activities (Miller, 2003). This provides further support for the proposition that a TQM organisation could be an ideal type of setting for investigating coordination from a communication perspective. Nevertheless, the review of TQM literature suggests the need for more empirical evidence for its linkage to both coordination and communication, given its existing literature is often conceptual-based or practitioner-oriented.

The literature review also shows some evidence that practitioners are struggling to achieve coordination and communication in TQM implementation. Therefore, apart from the study's primary objective of exploring characteristics of coordination from a communication perspective, this study also explores communication and coordination within an organisation that has successfully implemented TQM. As Zorn et al., (2000) noted, little attention has been paid to exploring communication within organisations that succeed in TQM implementation. The understanding of how an organisation that has successfully implemented TQM communicates and how such an understanding contributes to the understanding of TQM and coordination could provide insightful and valuable empirical evidence to TQM literature.

The review of literature in this chapter has established a linkage between coordination, communication and TQM as well as some research opportunities between them. Figure 2.1 illustrates the logical sequence of the process of literature review for this present study and the emergence of the study's research question.

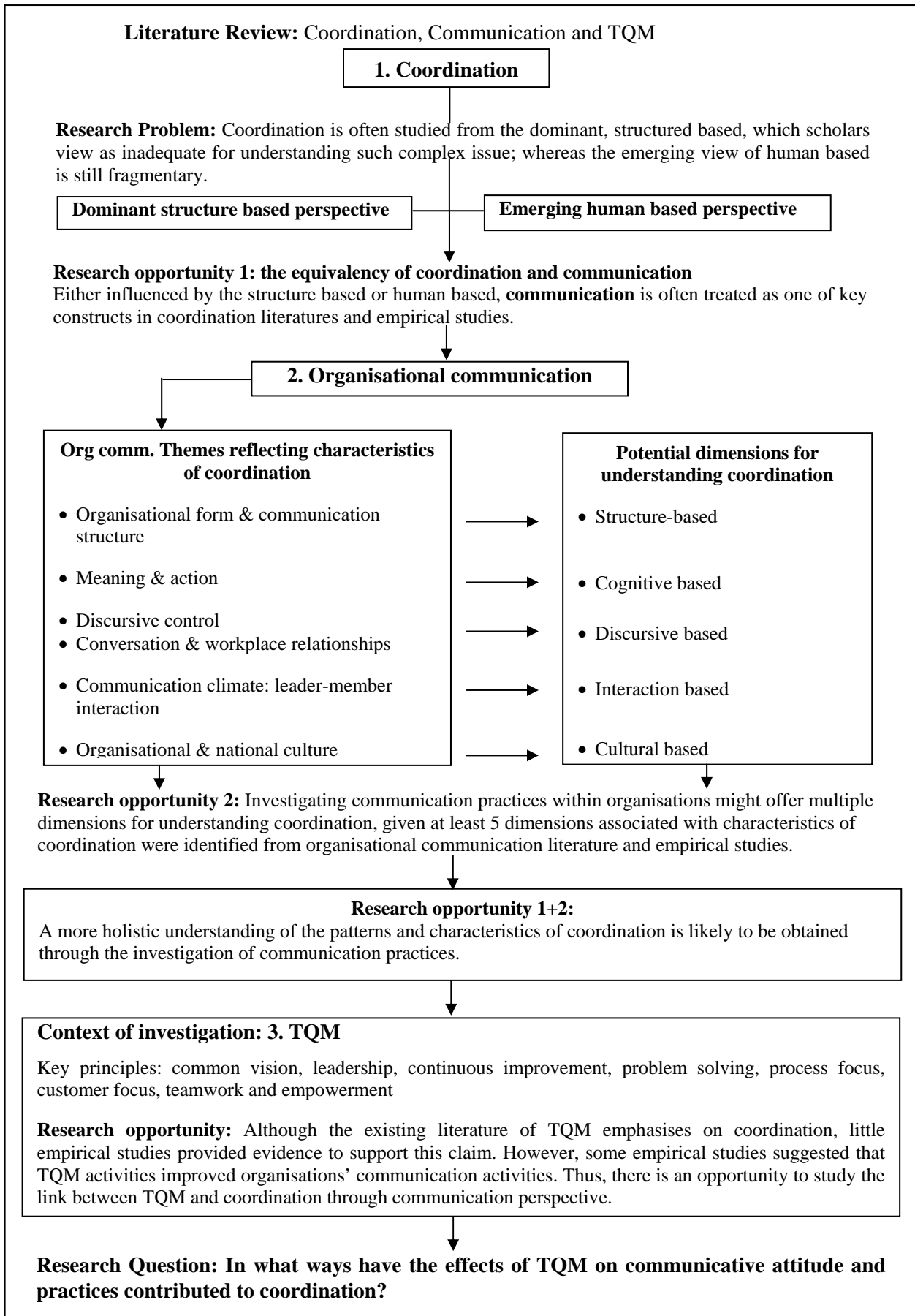


Figure 2.1: Literature Review and the Emergence of the Study's Research Question

This chapter has established the area of research focus upon which the research question was based and this will be the focus of the research methodology and design described in the next chapter.

Chapter 3

Research Methodology

The review of the literature in the previous chapter established the research focus on the need to explore the underdeveloped links between coordination, organisational communication and TQM. This chapter discusses the research design and methodologies to accompany the study's research focus and research question. The organisation of this chapter consists of three main sections: the rationale and details of the research approach, design and methods, the data collection procedures, and the analysis of data (including the philosophical perspective underpinning the analysis). Along with these, key issues and considerations taken up by the researcher to ensure the study was carried out in a rigorous and ethical manner are addressed.

3.1 Rationale and Details of the Research Approach, Design and Methods

The aim of the study suggests the need for an exploratory case study and the use of mixed methods including semi-structured in-depth interviews, participant observation, document analysis and a questionnaire survey to address the study's research question: *In what ways have the effects of TQM on communicative practices and attitudes contributed to coordination?* The rationale and details of the research approach, design and methods will be presented below.

3.1.1 An Interpretivist Approach

The choice of any research approach must be consistent with the assumptions concerning the nature of the phenomenon under investigation (Guba & Lincoln, 1998). There are two distinct assumptions about reality that form the foundation of social science research: *positivist* versus *interpretivist* (Putnam, 1983a). These two assumptions are often described as: *objective* versus *subjective* (Burrell & Morgan,

1979) and quantitative versus qualitative (Van Maanen, 1979). Generally, positivist (or objective/quantitative) is oriented toward verification and testing (Smircich & Calas, 1987) whereas interpretivist (or subjective/qualitative) is oriented toward discovery and exploration (Morgan & Smircich, 1980). Given that this study aims to develop a better understanding of the characteristics and patterns of coordination through a communication perspective, it can be categorised as discovery and exploration. Therefore, the present study falls into an interpretivist approach.

The interpretivist approach assumes that facets of the social environment are constructed as interpretations by individuals and that these tend to be transitory and situational (Robson, 2002). With this approach, knowledge is gained from an inductive hypothesis or theory generating mode of inquiry. The goal of interpretivist studies tends to develop concepts which help us to understand social phenomena, giving due emphasis to the meanings, experiences, and views of the participants (Morgan & Smircich, 1980). On the other hand, the positivist approach has been criticised for its lack of depth and richness (Robson, 2002), given that there are multiple realities within the world. The positivist approach tends to deny people's intentions, motivations and interpretations, which do not exist "out there", which change constantly and cannot be captured easily by standardised methods (Putnam, 1983a). Therefore, positivist methods may not be suitable when used to study ambiguous and complex social phenomena such as organisational activities including communication and coordination.

Qualitative methods are the main research strategy of this study. Qualitative inquiry is generally oriented toward the interpretation of experience and the inter-subjective construction of meaning, rather than control and prediction (Denzin, 1996; Geertz, 1983). Qualitative methods are particularly well suited for exploratory studies for which previous literature is limited (Cabtree & Miller, 1999). Patton (2002) argues that the strengths of qualitative methods lie in the ability to describe and contextualise phenomena. Denzin and Lincoln (2005) also point out that qualitative research involves an interpretive, naturalistic approach to the world in which the researchers study things in their natural setting, attempting to make sense of, or interpret phenomena in terms of the meaning people bring to them.

Nevertheless, despite being located in the interpretivist paradigm, the present study also employed some appropriate quantitative data to complement qualitative data. The two kinds of data were used simultaneously rather than sequentially due to the adoption of a triangulated approach which is a combination of methods in the study of the same phenomenon to minimise any bias inherent in the particular data sources and method when used conjunctively (Creswell, 1994). However, the detailed discussion of the adopted triangulation approach and the use of mixed research methods will be addressed after the discussion of the type of knowledge that the study aimed to produce and the study's research design.

3.1.2 A Practical Theory: The Knowledge Aimed to Produce

The present study aimed to produce localised knowledge on the characteristics and patterns of coordination through exploring communication attitudes and practices of a particular social context. This aim was consistent with the goal of interpretivist studies which tend to develop concepts contributing to an understanding of the social phenomenon being explored (Morgan & Smircich, 1980). Similarly, Putnam (1983b) considers that the interpretivist approach emphasises theory building, whereas the positivist emphasises theory testing. To obtain the localised knowledge which is called in this study as a practical theory, the research design of the present study was based on Eisenhardt's (1989) theory building case study. Prior to providing an explanation of a theory building case study and outlining its procedures, the following paragraph discusses the type of knowledge aimed to produce in this study, a practical theory.

Evered and Louis (1981) suggest two approaches for organisational studies: inquiry from the outside and inquiry from the inside. To them, the outcome of inquiry from the outside, seeks to know why, while the outcome from the inside, seeks to know how. This study sought the outcome from the inside given that it aimed to know how TQM was practiced within a particular setting. Alvesson and Deetz (2000) explain that humans continuously develop informed knowledge frameworks about how to act on things in their world, thereby formulating ways in which to understand and address issues and problems in the world around them. This notion is coherent with what Argyris and Schon (1996) called "theory-in-use" or "theory-in-practice", the informed

knowledge and experience frameworks that humans apply in their world. As such, the notion of localised knowledge and theory-in-practice underlined the term used in this study, a “practical theory”. The following section provides an explanation of a theory building case study and an outline of its procedures.

3.1.3 Case Study Approach to Theory Building

This study adopted a case study approach to theory building and used a framework proposed by Eisenhardt (1989) for guidance. There are several approaches to theory-building research including Dubin’s theory-building method (Dubin, 1978), grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998), ethnography (Van Maanen, 1995), and case study (Eisenhardt, 1989). However, the case study approach was considered as offering advantages for the theory building approach. This was because a study is most appropriate for the use of conceptual categories and pre-specified research procedures to uncover and interpret the phenomenon studied (Yin, 2003).

To explore the links between coordination, organisational communication and TQM, a broad conceptual framework which was developed from the review of literature was used to guide the data collection, analysis and interpretation. There is increasing agreement among qualitative researchers that having a theory in hand before going into the field can increase the validity of the study. Morse and Richards (2002) argue that without a theoretical framework, the researcher is in danger of providing description without meaning. Gummesson (1988) says that a lack of pre-understanding will cause the researcher to spend considerable time gathering basic information.

The use of a broad conceptual framework and planned data collection methods makes the case study different from other approaches to theory building, specifically to that of grounded theory, a research strategy highly regarded for its strength in theory building. According to Glaser (1978), one of the founders of grounded theory, what differentiates grounded theory research from most other research is that it is emergent without a tight focus on phenomena. In other words, grounded theory emphasises setting aside of a “preconceived” theoretical framework prior to and during the theory development (Glaser & Strauss, 1967). Given this, Dooley (2002) argued that

grounded theory research is generally more useful in the conceptual development phase of theory building than case study research.

Another reason for adopting case study approach was that the researcher was granted only four months to collect data at the organisation studied. Given such a limited timeframe, well planned data collection and research procedure was necessary to ensure obtaining the data required for understanding the phenomenon studied. This time constraint made less appropriate the use of other possible approaches such as ethnography or grounded theory. For instance, in grounded theory, Egan (2002) observed that the analysis activities are undertaken in response to ongoing data collection and comparison and are repeated until reaching a point of data saturation and a sufficient theory has emerged from the data. Because of the need for simultaneous data collection and analysis, Leonard and McAdam (2001) noted that grounded approach to theory building is appropriate for longitudinal studies. For these reasons, a case study approach was considered as an appropriate research strategy for this study.

To accompany the theory building approach, this study adopted a single-case, embedded design (Yin, 2003) based on Eisenhardt's (1989) suggestion that a single case study design is the most appropriate for the theory building purpose. This is because the single case design allows the researcher to thoroughly explore the phenomenon studied and fully engage with the participants and their localised communication action and pattern, thereby being able to obtain rich and detailed data to develop an understanding of a specific phenomenon. Apart from the theory building purpose, the single case design is seen as desirable for the study of TQM. Obtaining a rich understanding of TQM practice may contribute to the application and implementation of TQM, given most of the current TQM studies are based on the quantitative approach.

There are also some cautions for conducting a case study approach to theory building. One concern is the large volume of data. According to Eisenhardt (1989):

...given the typically staggering volume of rich data, there is a temptation to build theory which tries to capture everything. The result can be theory which is very rich in detail, but lacks the simplicity of overall perspective. Theorists

working from case data can lose their sense of proportion as they confront vivid, voluminous of data...(p. 574)

This point in fact occurred during the process of data analysis in this study. However, this issue will be discussed in detail later in the chapter. Another weakness associated with a theory building case study is in its bottom up approach which may produce a narrow result and limits the generalization of theory, as also noted by Eisenhardt (1989), “The risks are that the theory describes a very idiosyncratic phenomenon or that the theorist is unable to raise the level of generality of the theory” (p. 547). However, the researcher considers that this point of weakness was not as significant as the previous point because this study was influenced by the adoption of social construction² as a philosophical perspective underpinning the data analysis and interpretation.

Torraco (1997, p.123) defined theory building as: “the process of modelling real-world phenomena”. When applying this definition to social constructionism, a theory can be viewed as a set of systematically collected accounts or socially and culturally specific stories (Cronen, 1995). Rather than seeking to build a theory about how TQM had been effectively practiced, the theory built in this study focused on how the participants interpreted and practiced TQM in their own context. In this way, Eisenhardt’s (1989) case study approach served as guidance to obtain insights of a theory-in-practice and to systematically build up a localised knowledge, or a “practical theory”.

The use of a single case study as a research strategy may also be criticised as prohibiting generalisation of the findings (Miles & Huberman, 1994). However, the researcher was attracted to the “analytic generalization” of the case study proposed by Yin (2003). This way of generalization allowed the possibility for the researcher to generalize a particular set of results to some broader theory formed during the literature review (Eisenhardt, 1989; Yin, 2003). This case study was designed to be exploratory and inductive. The researcher allowed uncertainties of the research outcome to operate so that a conceptualized theory emerged from the data analysis of

² The social construction philosophy will be discussed in details in the data analysis section.

the case study, rather than, as Yin suggested, being developed deductively before any data are collected.

Similarly, Mitchell (1983, p. 207) pointed out that the validity of the extrapolation depends not on the typicality or representativeness of the case but upon the cogency of the theoretical reasoning, and that the case studies may be used analytically when the data are embedded in an appropriate theoretical framework. Therefore, the fact that the researcher conducted the study in accordance with methods of interpretation drawn from a theoretical framework may serve as a safeguard from the issue of subjectivity.

3.1.4 Research Procedures of a Practical Theory Building Case Study

The overall strategy of this research design involved the used of existing theories and concepts to inform the development of the study's operationalised conceptual framework. This framework was then used not only to guide the investigation but also to assist the analysis and interpretation of the localised knowledge obtained from the study. Finally, the analysed and interpreted localised knowledge was presented as a "practical theory". These processes are illustrated in Figure 3.1.

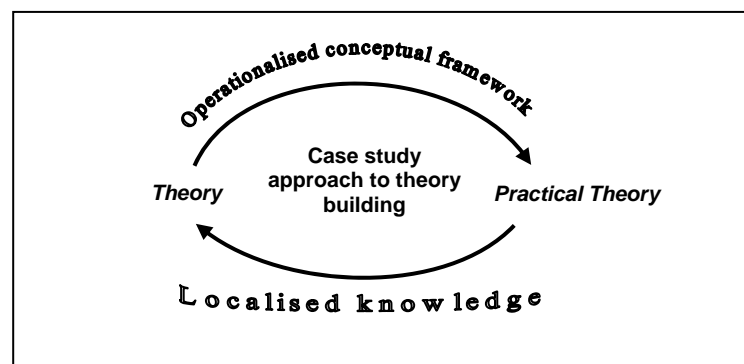


Figure 3.1: A Practical Theory Building Case Study

The research procedures involved in this study was adapted from Eisenhardt's (1989) process of "building theory from case study" framework, which offered eight steps approach to theory building. However, one step of "shaping hypotheses" as suggested in Eisenhardt's framework was not included in this study. This was because Eisenhardt's (1989) process of "building theory from case study" framework was seen as a way to obtain an understanding of localised knowledge in a systematic procedure; not as a way to develop research hypothesis or propositions. Therefore, there were

seven steps included in this study, and some of these were modified to suit this study. The research procedures involved in this study are listed in Table 3.1.

Table 3.1: Research Procedures of a Practical Theory Building Case Study

Step 1:	Formulating research questions, operationalised conceptual framework
Step 2:	Selecting the case through theoretical sampling
Step 3:	Designing data collection methods
Step 4:	Conducting the case study
Step 5:	Analysing data
Step 6:	Enfolding literature
Step 7:	Presenting a localised practice in a theory building format

Source: Eisenhardt (1989)

These steps may suggest a linear approach, but in practice, they did not progress sequentially. The researcher often moved between these stages to refine her thinking and revisit her analysis. All steps contributed equally in this thesis. However, the focus of this chapter is on step two to step five consisting of the selection of the case study, the design of data collection methods, procedures for conducting the study, and a framework for analysing the data.

To provide a backdrop for the discussion of steps two to five, the following paragraphs contain a summary of the process involved in the first step. The first step of this study was not different from other studies. The research questions of this study were refined several times through the process of literature review. In the end, the researcher chose to have only one main research question: *In what ways have the effect of TQM on communicative attitudes and practices contributed to coordination?*

The use of a broad research question was seen as suitable for the exploratory nature of the study and for the purpose of developing a practical theory. Not only could it accommodate key findings deriving from the emerging themes, it also allowed the constructed practical theory to be discussed and presented in a logical and holistic manner. This research question was asked after an extensive literature review process from which the links between coordination, organisational communication and TQM was established and used as a broad conceptual framework for the study. In the multiple level data analysis, the research question was unpacked into two sub-

questions. These were: (1) what was the effect of TQM on communicative attitudes and practices, and (2) how the effect of TQM on communicative attitudes and practices reflected on the understanding of coordination. However, in the final presentation, the analysed and interpreted data from the multiple level analysis were integrated to address the study's research question holistically, as a practical theory which illustrates ways in which the effects of TQM on communicative attitude and practices contributed to coordination.

3.1.5 The Conceptual Framework of the Study

Because the conceptual framework played an important role in the study, this section discusses the conceptual framework of this study. The discussion of step *two to five* of the study's research procedure will then be addressed in the last two sections of this chapter: data collection procedures and data analysis.

The conceptual framework was used to guide several steps along the study process: from selecting a case setting for the study; designing data collection methods; entering the case setting with a purposeful manner; to enfolding the literature in which the conceptual framework was used to compare and contrast the findings of the study. This latter process was similar to "pattern-matching theories" suggested by Yin (2003).

The use of a conceptual framework was seen to be appropriate for a study in an exploratory mode when it was used to provide the researcher with broad guidelines. The interplay of prior knowledge and discovery is critical in the process of making and developing concepts or ideas (Miles & Huberman, 1994). This implied the need for both deductive and inductive research approach for the study, given "in the life of conceptualization, we need both approaches" (Miles & Huberman, 1994, p. 17).

Given the nature of inquiry of this study, the conceptual framework was used as a "lens" to give a particular focus for the study. Despite having the conceptual framework in hand, the researcher was also prepared to be flexible during the execution in order to, as Janesick (2004) suggested, ensure valuable observations and related unexpected qualitative data could be obtained in an unplanned manner. Figure

3.2 presents the conceptual framework which illustrates the relationships among the study's three key constructs: TQM, organisational communication, and coordination.

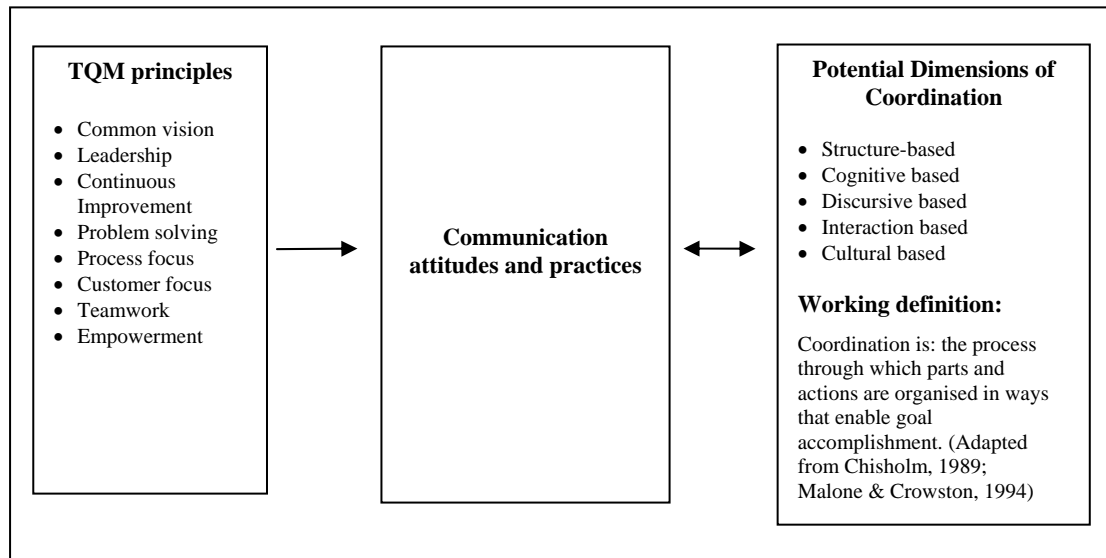


Figure 3.2: The Conceptual Framework of Study

According to the conceptual framework, eight key principles of TQM were identified through the literature review: *common vision, leadership, continuous improvement, problem solving, process focus, customer focus, teamwork* and *empowerment*. These identified principles were used to assist the researcher to differentiate between TQM and non-TQM practices during the data collection and analysis. Informed by the literature review, the study's conceptual framework assumed the equivalency of the characteristics of coordination and communication. Therefore, by investigating communicative attitudes and practices of staff members within the selected organisation, some possible characteristics and dimensions of coordination could be observed.

However, it is important to emphasize that, given this study is exploratory in nature, the use of the study's conceptual framework was to provide a "focus" for the researcher during the data collection and analysis. This means that the observation, analysis and interpretation of the effects of TQM on communicative practices and attitudes and its contribution to the emerging dimensions of coordination was not limited to those identified in the conceptual framework. Rather, the ultimate aim of

the study is to obtain some of the unpredictable features of the emergence of some characteristics and patterns of coordination.

3.1.6 The Selection of the Case Study Site and the Research Boundary

The selection of the case study site was based on theoretical sampling, in which the goal is to choose cases that are likely to replicate or extend the emergent theory or to fill theoretical categories (Eisenhardt, 1989). This study proposed to investigate the practice of communication and coordination within an organisation that has successfully implemented TQM. Therefore, the key criterion for choosing an organisation for the study was the successful implementation of TQM, rather than other organisational elements such as the type or size of business organisation, which are also important factors for studying organisations. Choosing an organisation that had successfully implemented TQM was a challenging task because, despite many claiming to have implemented TQM, not many organisations obtained tangible evidence, such as a certificate from a credible, authorised institution as evidence of success, such as ISO 9002 or quality awards.

Several organisations in Thailand that met the case selection criteria were approached but did not express an interest in participating in this study. One of the largest telecommunication companies expressed their interest and agreed to participate in the study. However, it withdrew after several discussions on the scope of study, because a senior management official could not agree on the length of time of the study and on the proposed research methods, participant-observation. Finally, through an endorsement of a senior public official from one of national health bureaus, the researcher was able to obtain access to one of the largest, private hospitals in Bangkok.

However, the researcher eventually had to adjust the scope of the study because of the complex nature of the hospital. Hospitals are viewed as one of the more complex types of organisation (Costello & Pettegrew, 1979) because they consist of medical and non-medical treatment working units. Therefore, the area of investigation was limited to non-medical treatment: *back office* and *front office*. The back office consisted of administrative, TQM, human resources, education and training, accounts, and marketing. The front office was the customer-support service department. Within

this department, there are several units including customer service, call centre, international patient centre, security, catering, maintenance and housekeeping. Although the case study research design is viewed as suitable for studying a highly complex organisational setting, the exclusion of the medical-treatment-related working units allowed the researcher to investigate the phenomena more thoroughly thereby obtaining rich, insightful information. More importantly, given that she did not have a background in medicine, conducting the study in the non-medical treatment area allowed her to better comprehend the phenomenon studied.

3.1.7 Ethical Consideration Issues

This study employed research methods in studying respondents' attitudes and behaviour in their daily working context and the analysis involved interpretation of meaning. Therefore, the researcher took great care to ensure the study was carried out ethically. Three ethical issues were taken into account to protect all parties: confidentiality, privacy and freedom from coercion. At the beginning of the study, the proposed research methodology, research instruments, and the ethical code of conduct were approved by University of Canberra Committee for Ethics in Human Research and the executive official of the hospital studied.

The data collection process was carried out in accordance with the university's ethical code of conduct. When participants were first approached, they were informed about the purpose and procedures involved in conducting the study. More importantly, they were clearly informed that the decision to participate in the study was voluntary. They could decline to answer some of the questions or withdraw from the study at any stage without penalties. The participants who agreed to participate were reassured about the safeguards used to protect their privacy and identity before being asked for their consent to participate by signing a written consent form. During the study, participants were treated as experts who had knowledge and experience in the field and therefore, the researcher refrained from interfering with, or influencing their responses. Those who participated in the interviews were asked for their permission to be taped. These ethical considerations allowed the researcher to obtain confidence and trust from the participants which, in turn, allowed her to obtain some surprising, unexpected, yet valuable, insightful information.

The “confidentiality” and “privacy” ethical considerations were strictly followed, particularly during the data analysis procedure. All information collected was treated in a confidential manner; a coding system was used to protect the privacy of participants and to safeguard their identities. Therefore, no reference was made to any individual or institution in the analysis and reporting of data. Finally, the information related to the research project was kept confidential and securely stored at the university and will be destroyed five years after the completion of the study.

3.2 Data Collection Procedures

This section mainly addresses two steps in a practical theory building framework of this study: designing data collection methods (step three) and conducting the case study (step four). This section consists of three sub-sections: data collection strategy, the pilot study and the actual study.

3.2.1 Data Collection Strategy: Multiple Methods

The research question, the nature of social constructionist epistemology, and the nature of ontological complexity suggested the need for multiple methods of data collection. This study adopted multiple research methods of in-depth interviews, participant-observation, document analysis and questionnaire surveys. One of the advantages that a case study research offers is that it welcomes the use of various research methods which, according to Yin (2003), allows the researcher to “triangulate” evidence from different data collection sources. Many researchers have agreed that the use of multiple methods is the most accurate way to capture the idiosyncrasies of an organisation because the vantage point from which researchers look at a phenomenon determines what it is that the researcher will see. No one vantage point provides a complete picture (Kincheloe, 2005). Dingwall (1997) began the move toward constructivism by arguing that triangulation offered a way to reveal multiple constructed realities. Constructivists acknowledge the social construction of knowledge by the researcher and the researched, and assume that there are many possible interpretations of the same data, all of which are potentially meaningful (Guba & Lincoln, 1994).

In this study, each research method was used with a different degree of contribution: either as *primary* or *secondary* source of data collection. The in-depth interview method was adopted as a primary source of data collection, while the other three research methods were adopted as a secondary and combinative source of data. The reason for choosing the in-depth interview as the primary data source was that it provides a flexible and effective method for acquiring data from which theoretical insights can be developed (Seidman, 1998). Despite producing rich and insightful data, the researcher cannot rely only on the data obtained. As such, a secondary set of data collection was designed to complement the primary data, the interviews. This will provide a richer interpretation of the phenomenon studied. For instance, while observation allows the researcher to make assumptions about the environment, “interviews are especially useful for understanding how people make sense of their work and the issues they believe are important” (Barley & Kunda, 2001, p.84). This study used three research methods as its secondary data sources. The secondary sources of data were used to support or question the findings emerged from in-depth interview. Figure 3.3 provides an overview of research methods and types of data collection.

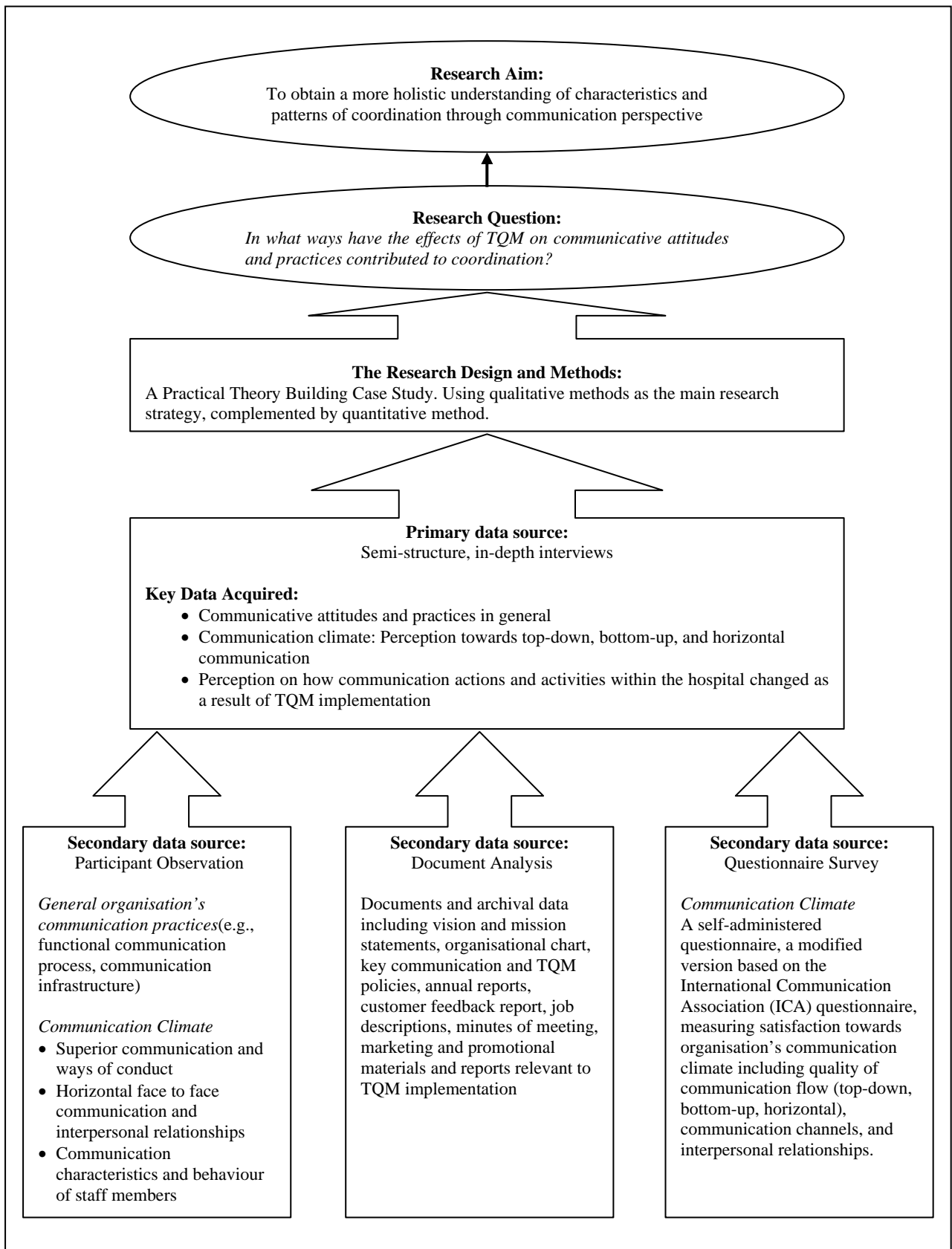


Figure 3.3: The Study's Research Methods and Data Sources

3.2.1.1 Semi-Structured, In-depth Interviews

A semi-structured, in-depth interview strategy was considered appropriate in this study because it allows in-depth exploration of individual views and perspectives with the use of question guidelines (Sarantakos, 2005). Although the unstructured interview allows a richer and authentic view regarding the respondents' unique experiences and the way they make sense of the phenomenon investigated, this strategy was not feasible in this study. To obtain quality responses, conducting unstructured interviews requires both quality and quantity of time which was not possible due to limited period of time for accessing the case setting as well as the busy working environment of the hospital. In addition, in this study, the researcher aimed to compare and contrast the view between sub-units. Achieving this demanded that the key issues to be covered by as many respondents as possible.

The selection of interviewees for in-depth interviews in this study was based on a purposive sampling technique (Babbie, 2005). Purposive sampling method was seen as appropriate for selecting interviewees because it served the purpose of the study which aimed to obtain a localised knowledge of the characteristics and patterns of coordination through communication perspective. There were two criteria for selecting the interviewees. The first was that they should have had at least five years of work experience at the hospital studied, and the second was based on their roles and responsibilities.

Given that localised knowledge was sought in this study, purposive sampling allowed the researcher to recruit interviewees who could articulate their knowledge and ideas and who showed their willingness to participate in the study. As the initial list of desired interviewees was modified by the researcher's further knowledge developed during the first two months of participant-observation (i.e., a better understanding of which informants she needed to interview), purposive sampling provided the flexibility to recruit potential interviewees. Finally, the use of purposive sampling based on the specified criteria is seen to be more appropriate for in-depth interviews than the use of representative sampling from a 'frame' of a listed population (Wengraf, 2001) because the depth of issues uncovered is more important than the numbers of interviewee.

The interview guidelines were developed to explore the respondents' communicative attitudes and practices in general and in the specific context of TQM implementation. The main emphasis was on how they perceived communication actions and activities within the hospital to have changed after TQM. The question guideline was designed to be open and flexible. The researcher had the freedom to determine the order of questions; to formulate new questions and to follow up with probes by asking for specific events, situations, and examples to illustrate a particular point. Guideline questions for the in-depth interview are listed in Table 3.2.

Table 3.2: In-Depth Interview Guideline Questions

<ol style="list-style-type: none"> 1. What do you consider as a good communication? Have you seen it in the hospital? 2. What are the major communication strengths and weaknesses of the hospital? 3. After implementing TQM, in relation to internal communication, what has got better and what has got worse? 4. From the following TQM principles: customer focus, leadership, teamwork, continuous improvement, process focus, problem solving, continuous improvement, empowerment and common vision, what are principles you found related to the effective (or ineffective) of your organisational communication? Please explain 'why' and give examples. 5. Overall, how are you satisfied with your communication experience in the hospital?

However, in-depth interviews also have their drawbacks. One disadvantage is that the researcher may not be able to control what Gomm (2004) called "Hawthorne effects", according to which, some respondents may answer questions in a way they would not otherwise do, because they knew they are being researched. To minimise this, the researcher adopted some characteristics of ethnographic and narrative interviews to create an informal, friendly atmosphere, a conversation-like interview session in the hope of encouraging respondents to feel free to discuss in more detail issues which they considered particularly important, or to share their experiences or stories related to TQM implementation.

3.2.1.2 Participant-observation

Participant observation is a typical data-collection method occurring in the natural setting in which the participants are located (Adler & Adler 1994). The method consists in gathering data by participating in the daily life of the group or organization' studied. A researcher observes the people in their daily routines, enters

into conversations with some or all of the participants in these situations and discovers their interpretations of the events observed (Wiersma, 1995). Observation is viewed as the cornerstone of qualitative inquiry, particularly when relying on direct experience (Janesick, 2004). Observation was adopted as a secondary source of data due to the limited time available for the study. In-depth interviews, were seen as proving more effective use of the limited time than extensive participant observation. However, when used as a secondary source and in combination with other methods, participant observation could provide rigour for the research design. This study particularly emphasised the combination of observation and in-depth interview data sources for its ability to elicit contradictions between communicative attitudes and behaviour.

The purpose of the participant-observer is to ensure that the observations register the phenomenon in its natural occurrence. In this particular field study, the focus was on capturing staff members' communication and interaction in their routines, as well as in activities and events organised by the hospital studied. This feature assists with the validation and interpretation of information provided by participants during subsequent interviews (Morse & Field 1996). According to Bryman (2004), observation can illuminate the discrepancies between what people said in the interviews and casual conversations, and what they actually do.

Observations also help elicit the implicit communication attitudes and practices which may not be covered in the interviews because, in Schein's (2004) words, they may be overt or subconscious, below the level of awareness. As such, Schein (2004) posits that the communication artefacts and rituals of an organisation often serve as a reflection of the deeper levels of culture—the values and underlying assumptions that guide the behaviour of organisational members. Given that any communication activities have a meaning attached to them, the researcher ensured the observation design was sensitive to the issues pointed out by Schein.

Nevertheless, there are some limitations for conducting participant-observation. Yin (2003, pp. 94-96) warned the major problems included the potential for producing biases and the neglect of note taking. This study planned to address these issues

through the use of triangulation of data sources and field notes. In addition, an observation list was prepared to ensure that the observations covered all aspects and activities required for the study. Hammersley and Atkinson (1983) warn against the potential for capture or “going native”, where the researcher becomes so immersed in the research setting that they are unable to provide any level of objectivity in both reporting and analysis. Therefore, they suggest that while researchers need to develop a trusting relationship with participants and to “fit in” so that the researcher’s presence causes as little disruption as possible to normal activities, a balance is needed to establish a sufficient distance between the researcher and the observed participants to make sense of the observations (Hammersley & Atkinson, 1983).

Finally, there is the concern over the ethical issue of observing individual behaviour. This issue was protected by following the ethical code of conduct approved by the University of Canberra Committee for Ethics in Human Research. All participants were aware of the researcher’s status, and the nature of the research. As referred by Jorgensen (1993, p. 45) there are two basic strategies to gaining access to phenomena of interest when using participant observation technique: overt and covert. The strategy chosen in this study was overt as the researcher openly requested permission to observe.

3.2.1.3 Document Analysis

Documents were considered to be a valuable source of data to complement the data from in-depth interviews and participant because they are an explicit form of communication practice. When used as a secondary source and in combination with other methods, document analysis can add strength to the study in several ways. First, with the limited time available for the study, document analysis was planned to use as an input to the interview process and to save the researcher time asking for facts in the interview. Second, given that historical data is central to the epistemological understanding of phenomenon studied, document analysis allowed tracing the history of the organisation and statements made by key people in the organisation. The third issue was based on Schein’s (2004) notion of communication artefacts, which often serve as a reflection of the underlying assumptions that guide the behaviours of organisational members. Analysing documents such as mission and vision statements, organisational policies, organisational structure, working procedures and

job descriptions, therefore, enabled the researcher to elicit what has been said and what has been practiced within the organisation studied.

Finally, document analysis was seen as adding strength to the triangulation of data. Yin (2003) viewed documents as playing an explicit role in any data collection, and therefore, he found the most important use of document is to corroborate and augment evidence from other sources. Among several points of usage suggested by Yin (2003, p. 87) two were of particular interest to this study. The main usage was related to counteracting the biases of the interviews, which may arise from participants and bias of the observations, which may be caused by the researcher, as well as verifying the correct spellings and titles or names of organisations that might have been mentioned in interviews.

Like other methods, document analysis has disadvantages. One of them is the potential over-reliance on documents in case study research resulting in a mistaken assumption that all kinds of documents contain the unqualified truth (Yin, 2003). As such Yin (2003, pp. 87-88) warned that a researcher should be aware that every document was written for some specific purpose and some specific audience other than those of the case study being done. To avoid being misled by documentary evidence and more importantly to be correctly critical in interpreting the contents of such evidence, each document collected was examined for its objectives and purposes prior to the analysis.

3.2.1.4 Questionnaire Surveys

This study adopted the quantitative approach of a questionnaire survey to complement the other three qualitative methods, specifically on the communication climate issue which concerns respondents' attitude towards communication practices within an organisation. Adopting questionnaire surveys for a complementary purpose was supported by Sale, Lohfeld, and Brazil (2002) who argued that mixed methods can only be used for complementary purposes, and not for triangulation (by this they mean as a way of cross-validation when multiple methods produce comparable data). According to them, qualitative and quantitative research paradigms are not studying the same phenomenon.

As noted by Babbie (2005, p. 285), survey research does not often deal with the context of social life, because it can not measure social action, and it can only collect self-reports of recalled past actions or of prospective actions of respondents. When conducted with a complementary objective, the survey was used in this study to provide the data on an overall impression of “communication climate” of the organisation studied from a larger group of respondents’ point of view. The survey data were expected to complement not only the researcher’s impression of the studied organisation’s communication climate developed during participation observation, but also the responses obtained from in-depth interviews which were conducted in a smaller sample size.

Based on this purpose, the researcher adopted a “purposive sampling” technique based on available subjects (Babbie, 2005) for its data collection. Having respondents participate on a voluntary basis was believed to enhance the quality of the result. This was because the design of the questionnaires was based on the Likert’s 5-, 7-, 10-point scales, so the respondents may be more careful and invest more effort to ensure their ratings best reflected their views. More importantly, the use of purposive sampling was seen as appropriate for the study, given the hospital’s busy working environment and the constraints of time allowed by the organisation studied and the PhD research budget. Although the use of a cross-section sampling technique was considered because it could provide a better representation of the hospital’s population, the use of such technique was not possible due to the research constraints mentioned above.

The questionnaire used in this study was a self-administered questionnaire, a modified version based on the International Communication Association (ICA) questionnaire, which has been shown to have validity, reliability and utility in measuring organisational communication (Hargie & Tourish, 2000). The ICA questionnaire was originally developed as a tool for communication audit and was divided into a number of sections; each section deals with a different aspect of communication practice and climate. The respondents would be asked to rate each statement, using the Likert’s scale, along with two dimensions of measurement: “how it is now” and “how you would like it to be”. For instance, in section on “amount of information being sent”,

respondents are asked to rate each, using a five-point scale, along two dimensions of measurement: “amount of information received now” and “amount of information needing to be received”. The use of two measurement dimensions allows making a comparison of improvement in communication between two periods of time and thus, the ICA questionnaire is commonly viewed as an ideal tool for conducting benchmark studies and communication audits.

However, in this study, the main aim of using this survey instrument was to obtain a snapshot at a given point in time. Therefore, instead of asking the respondents to rate each communication item in two dimensions of “real” (how it is now) and “ideal” (how you would like it to be), in this survey, the respondents were asked to rate each communication item in two dimensions of “importance” and “satisfaction”. For instance, one section asked how the respondents feel about the amount of information they are receiving. To address this, the respondents were asked to rate two boxes: *box one* indicated the “degree of importance” they perceived towards the information they are receiving now, while *box two* indicated the “degree of satisfaction” they have towards the information they are receiving now. It may possible to measure the degree of satisfaction without referring to the degree of importance. However, measuring only the degree of satisfaction may cause respondents to spend their time rating their satisfaction levels of things that do not matter to them. Therefore, in scoring the items, multiplication of the level of importance with the level of satisfaction assigned to each item provided the score for that item so called, satisfaction index (degree of importance X degree of satisfaction = satisfaction index).

There were eight sections based on the ICA questionnaire included in the questionnaire. In addition, one section on TQM principles and communication practices was added to the questionnaire to cover all the key issues investigated in this study. Table 3.3 presents nine sections included in the questionnaire survey.

Table 3.3: Sections Included in the Questionnaire Survey

Section A	Satisfaction with the amount of received information
Section B	Satisfaction with the amount of information you send
Section C1	Satisfaction with people sending information to you
Section C2	Satisfaction with people taking action on information you send
Section D	How quickly do you get information from given sources?
Section E	Satisfaction with the amount of information you are receiving through these channels
Section F	Working relationships
Section G	Satisfaction with the hospital internal and external communication
Section F	TQM principles and communication practices

Apart from limitations on the use of questionnaire surveys in studying the context of social life (Babbie, 2005), there are weaknesses inherent in the use of questionnaire surveys. One is due to the nature of a self-administrated survey. Without the presence of the researcher during the time the respondents fill in the questionnaires, it is important to ensure the questionnaire is clear, comprehensible and easy to follow in order to obtain a valid result. Therefore, the questionnaire surveys were conducted in a pilot study in order to obtain feedback for improving clarity and overall comprehension of the questionnaire.

3.2.2 The Pilot Study

To avoid pitfalls, a pilot study was planned to test the research instruments as well as to provide a chance to rehearse procedures involved in the study prior to the actual study. Given in the nature of qualitative inquiry that researchers are viewed as a “research instrument” and that the process of data collection and analysis occur simultaneously (Morse & Richards, 2002), conducting a pilot study was seen as an important step to allow the researcher to get acquainted with the research procedures.

The selected pilot case studying setting was a regional, public hospital in Chiangrai province of Thailand. A purposive method was used for selecting the pilot case study setting to ensure the case study was compatible with the actual study setting as far as possible. There were not many choices for the selection because, at the time of the study, there were relatively small numbers of private hospitals with a Hospital Accreditation (HA) certificate. More importantly, due to the competitive market

among private hospitals, the hospitals approached were not interested in participating because of confidentiality concerns. Although the hospital selected for the pilot study was a public hospital, it was considered a good match for the actual case setting because both the pilot and actual case setting were the first large-sized public and private hospitals that received HA certification in a similar period.

The respondents involved in the pilot study were from non-medical treatment areas including management, administration, public relations, cleaning and security services. There were 12 participants for the interviews: six from the management level and six from the operational level. As for the questionnaire surveys, it was conducted among 50 respondents, which were equally divided between the management and operation staff. Finally, the researcher spent about 25 hours for participation observations. Due to the time limit, document analysis was not included in the pilot study.

There were some modifications made to the research procedures and instruments for the actual study. For instance, instead of conducting all of the data collection methods almost simultaneously, starting the data collection with participant-observations and document analysis were found to be more efficient because the researcher could develop an overall impression of the hospital and its people prior to the interviews. More importantly, it was also hoped that the relationships and trust developed between the researcher and participants during the observations would allow obtaining fruitful information from the interviews.

As for the research instruments, the interview guideline was revised by concentrating more on TQM and communication practices than on communication attitudes in general. Questions on experiences and incidents regarding communication changed through TQM implementation were added to obtain more insightful and, thus, allowed rich interpretation of data. For the questionnaire surveys, one major change made was shortening the length of the questionnaire. Despite incentives being provided to the respondents to encourage them to give more attention and effort in filling up the questionnaire, respondents commented that the questionnaire took a long time to complete. As such, section F, which was believed that other methods could

gather rich and insightful data without the complementary from the survey, were deleted.

3.2.3 The Actual Study

This section addresses three main issues involved in conducting the actual study: the sampling units, the sampling achieved and the study procedures.

3.2.3.1 Sampling Units

This study was conducted among the respondents working within the non-medical areas of the hospital. There were two categories with two sampling units in each: (1) the category of hierarchical level consisting of *management level* and *operational level* and (2) the category of divisional level consisting of *back office* and *front office*. All together, there were four sampling units in this study, as shown in Table 3.4.

Table 3.4: Sampling Units

(1) Hierarchical level	
Management level Top management Middle management	Operational level Operational staff with no subordinates
(2) Divisional level	
Back Office Executive management, Human resources, Education and training, Total Quality Improvement, Employee relations, Finance	Front office International centre, Customer service, Translators, Call centre, Catering, Housekeeping, Securities, Maintenance

However, the comparison between the sampling units was conducted within each category (management versus operational, and back office versus front office), not between sampling units across categories (i.e. management versus back office). It was not considered relevant to conduct a comparison between sampling units outside these categories. This was because the two categories, hierarchical and divisional level, represented a different perspective and, thus, they were used to complement one another to ensure the sampling units were well covered in the study. Having sampling units based on the two categories also provided more opportunities to conduct an extensive analysis and obtain insightful data, particular for data gathered from the primary source, in-depth interviews. This meant one response obtained from a

participant represented two sampling units: one under the hierarchical level (either as managerial staff or operational staff) and another under the divisional level (either from the back office or from the front office).

Although having multiple units enhanced the insights obtained and minimised the researcher's and the respondents' biases, one major drawback of the embedded, single case design is that, according to Yin (2003), "if too much detail is sought in the sub-units, and that if the larger, holistic aspects of the case begin to be ignored, the case study itself will have changed its nature" (p.46). This issue was particularly important for this study because its main aim was to obtain a holistic understanding of how TQM interacted with the communicative attitudes and practices leading to an understanding of the coordination patterns of the organisation studied. To prevent this, the researcher looked for ways to accommodate similarities and differences within and between sub-units and explained the phenomenon studied as an integrated whole.

3.2.3.2 Sampling Achieved

The selection of the interviewees for in-depth interviews was based on a purposive sampling technique (Babbie, 2005). This was to ensure that not only that they were representative for the study, but also that their knowledge and experiences allowed them to provide useful and insightful information. As such, two criteria were used to recruit the interviewees: (1) years of working and (2) role and responsibilities. For the first criterion, the qualified interviewees should have been working at the hospital for more than five years at the time the study was conducted³ so that they could provide a comparison of communication practices "before" the adoption of TQM intervention and "after" the hospital had received an award for successfully implementing TQM. The second criterion was based on their role and responsibilities which had to match one of the sampling units.

³ This was except for one respondent from the management level who has been working at the hospital for less than five years. This manager was included in the study because of the significance of roles and responsibilities.

Initially, it was planned to obtain 40 interviewees with a quota of 10 interviewees for each sampling units. However, the study was concluded with a total of 36 interviewees. There were 18 interviewees representing the management level, of which ten interviewees were from the back office and eight were from the front office. The sampling achieved from the operational level also arrived at the same number of 18 interviewees and with equal numbers of nine interviewees from the back office and the front office. Most of the interviewees were Thai nationals, except for four interviewees who were non-Thai (for the hierarchical level: three were from the management and one from the operation, as for the divisional level: one from the back and three from the front office). Table 3.5 provides a summary of the number of sampling achieved for the in-depth interviews while Table 3.6 provides a detail of interviewees

Table 3.5: Sampling Achieved for In-Depth Interviews

Hierarchical level	Management (N=18)	Operation(N=18)
Divisional level		
Back office (N=18)	10	9
Front office (N=18)	8	9

Table 3.6: A Detail of Interviewees

No.	Gender	Position	Location	Years of working
1	Male	Top management, management	Back office	8
2	Female	Top management, quality management	Back office	24
3	Male	Top management, marketing (foreigner)	Back office	17
4	Female	Top management, human resources	Back office	7
5	Male	Middle management, administrative	Back office	21
6	Male	Middle management, IT	Back office	15
7	Female	Middle management, quality management	Back office	12
8	Female	Junior management, administrative	Back office	20
9	Female	Junior management, employee relations	Back office	6
10	Female	Junior management, quality management	Back office	18
11	Female	Operation, secretary	Back office	5
12	Male	Operation, clerk	Back office	16
13	Female	Operation, secretary	Back office	7
14	Female	Operation, education	Back office	5
15	Female	Operation, training coordinator	Back office	8
16	Male	Operation, webmaster	Back office	7
17	Female	Operation, officer	Back office	11
18	Female	Operation, officer	Back office	6
19	Male	Operation, support officer	Back office	7
20	Male	Top, management, Support services (foreigner)	Front office	1*
21	Male	Top management, International centre (foreigner)	Front office	6
22	Female	Middle management, customer service	Front office	10
23	Male	Middle management, maintenance	Front office	15
24	Male	Middle management, catering	Front office	8
25	Male	Middle management, security	Front office	12**
26	Female	Middle management, housekeeping	Front office	9
27	Female	Junior management, VIP service	Front office	8
28	Female	Operation, admission and registration	Front office	6
29	Male	Operation, customer service	Front office	5
30	Female	Operation, customer service	Front office	13
31	Female	Operation, translator (foreigner)	Front office	6
32	Male	Operation, translator	Front office	6
33	Female	Operation, call centre	Front office	10
34	Male	Operation, security	Front office	13
35	Female	Operation, housekeeping	Front office	7
36	Female	Operation, cashier	Front office	5

Remarks:

*Although this respondent did not pass the criteria of having at least 5 years of working, he was included in the study because of the significance of roles and responsibilities as well as his insightful information.

** This respondent was not employed by the hospital but a sub-contracted company. However, the hospital has included him as one of its staff member who is required to follow the hospital's routines as well as attending activities including meeting, training and workshop.

The questionnaire surveys were conducted within the research boundary which has a total population of 792 staff (non-medical staff only). A total of 300 questionnaires

was distributed to the hospital staff members using a purposive sampling technique based on available subjects (Babbie, 2005). At the end of the study, the researcher obtained a response rate of 90% (269 valid, returned questionnaires). For the hierarchical category, there were 66% of the respondents from the operational level (n=178) and 34 % from the management level (n=91). As for the divisional category, there were 68% (n=183) from the back office and 32% (n=86) from the front office. Table 3.7 and 3.8 provide a summary of the sampling achieved from each category.

Table 3.7: Sampling Achieved of Hierarchical Level for Questionnaire Surveys

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Management (top and middle)	17	6.3	6.3	6.3
	Managers	74	27.5	27.5	33.8
	Operational staff	178	66.2	66.2	100.0
	Total	269	100.0	100.0	

Table 3.8: Sampling Achieved of Divisional Level for Questionnaire Surveys

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Front Office	86	32.0	32.0	32.0
	Back Office	183	68.0	68.0	100.0
	Total	269	100.0	100.0	

3.2.3.3 Research Procedures

Besides the experience and improvements made from the pilot study, the necessary timeline obtained for the actual study enabled the researcher not only to efficiently carry out all of the data collection methods but also to carefully review and grasp an understanding of the key issues being uncovered. The actual study was conducted during a period of four months, from August - December 2004.

The first two months were spent mostly undertaking *the participant observation component and document collection as well as preparing a list of interviewees*. The participant-observation went very well because the hospital staff, management in particular, were very cooperative and supportive. The researcher was granted free access to go inside all working units and attend activities organized for the staff inside

the hospital. More importantly, with the help from one executive staff member, an observation schedule was arranged for the researcher for a three day visit for each unit within the research boundary.

A visit to each working unit usually began with a half morning with a manager or a person in-charge who showed the researcher around their working unit, introduced their staff, and explained their scope of work. Then the remaining two and a half days were spent observing communications and interaction among staff in their daily working routine. The researcher was also invited to attend several activities organised for the hospital's staff including the three-day employee orientation, quality improvement training, workshops, and special social events organized for the staff such as a monthly birthday party. During the observation, the researcher took notes from a general impression of working units, events as well as people met, specific issues observed from staff members' communication and interaction, to descriptions and explanations provided by the staff. Notes on informal conversations with some staff members during lunches and coffee breaks were also taken once the researcher returned to her allocated desk.

Having these opportunities allowed the researcher to observe and converse with the staff. The relationship created between the researcher and the staff enabled the researcher to approach some staff to participate in the in-depth interviews as well as developing a list of staff who expressed their interest to participate in the questionnaire surveys. It was found that the relationship and trust which developed between the researcher and the hospital staff made the whole study process a warm and engaging one. For instance, the collection of documents, especially those that were not available for the public access, was initially thought to be a challenging task. However, it turned out to be effortless thanks to the cooperation available from the hospital managerial staff.

Apart from the documents made available to the public such as the hospital's mission and vision statements, internal newsletters, and information brochures, the researcher was allowed to access the hospital online documents database which contained all of the hospital's documents such as working policies, quality improvement policies,

quality improvement plans, and job descriptions. The researcher was also allowed access to hard copy documents such as the hospital annual reports, meeting memoranda, and some statistical reviews on the hospital's business performance and quality improvement surveys.

The last two months were mostly spent on the *in-depth interviews and distributing and collecting the questionnaire surveys*. These two methods were conducted almost simultaneously, with the questionnaire distribution starting one week before the interviews started. One third of the questionnaires were distributed by the researcher through the expression of interest list previously collated during the observation period. The rest of the questionnaires were distributed by working unit managers. The fact that the questionnaires were distributed during the time the researcher was conducting other research methods inside the hospital allowed unexpected opportunities for the researcher to observe some staff during the time they filled the questionnaire, as well as receiving spontaneous comments and responses from some of the respondents. The feedback points brought up by some respondents provided a chance for the researcher to further explore or discuss issues with the respondents, either in the interviews or during informal conversations, which mostly occurred during lunch times.

In relation to the interviews, two main approaches were used to recruit the interviewees. Most of the interviewees who worked at the operational level were recruited by the researcher through personal contact made during the first two months of observation, while the interviewees from the management level were purposively selected because of the significance of their role and responsibilities. The interviewing sessions began with a brief introduction to the study and covering ethical consideration issues, particularly the interviewee's rights (see Appendix A and B).

All of the interviewees were asked for their consent to the use of a tape recording. The interviews were conducted inside the hospital and lasted between 30 and 75 minutes. The interviews among the operational staff, particularly those from the front office, were often shorter than others due to the constraint of their busy work schedule. The experiences obtained and the changes made from the pilot study, and

the relationships created between the researcher and the interviewees prior to the interview session resulted in informal, relaxing interview sessions, which enabled the researcher to be more flexible in exploring further details on interesting issues brought up by the interviewees.

Although the interview guide provided a number of broad areas on which the information was sought, many times the researcher followed the leads of the interviewees, probing from things they said and occasionally steering the interviews. The researcher was both surprised and delighted at how candid the interviewees were during interviews. More importantly, it was found that the data obtained during participation observations mutually interacted with those from interviews and occasionally, it allowed the researcher to probe what she had observed.

Most of the interviews went smoothly, except for some circumstances where the interviewees were interrupted and needed to break off the interviews. However, the disrupted interviews were later resumed and completed at a later time. The interviews were conducted in Thai except for four interviews with foreign staff which were conducted in English. All the interviews were transcribed and translated into English (prior to the data analysis, so that the input data were compatible with the qualitative data analysis software, Nvivo, which operates in English). However, to ensure that the translations would best capture and reflect the original responses of the interviewees, the translated interview scripts were reviewed by a native English speaker who has studied the Thai language for more than 10 years.

3.3 Data Analysis

At this fifth stage of the practical theory building case study, data analysis, there were four types of data: interview scripts, participant-observation field notes, document analysis records, and the questionnaire survey results which were isolated from the social reality. Holliday (2002) views the data at this stage as “messy reality” and argues that “although these data can be viewed as the closest to reality of the setting, raw data cannot simply be left as it is” (p. 101). This is where the role of the researcher as “an interpretive-bricoleur” (Denzin & Lincoln, 2005) was adopted.

Denzin and Lincoln (1994) viewed the product of the interpretive bricoleur's labour as, "a bricolage, a complex, dense, reflexive, collage-like-creation that represents the researcher's images, understandings, and interpretations of the world or phenomenon under analysis" (p. 3). This inspiring notion of bricoleur was adopted after the researcher encountered what Eisenhardt (1989) called, the "staggering volume of rich data" during the data analysis and that the complexities of data forced the researcher to change the data analysis framework and re-analyse her data several times.

In addition to the adoption of the notion of researcher as an interpretive-bricoleur, this study also discovered the notion of social construction as providing a useful addition to iterative data analysis. Because social constructionism has fundamentally shifted the way the researcher interpreted and analysed the data obtained in this study, this section begins with the philosophical underpinning data analysis, social construction. It then discusses the study's data analysis procedures.

3.3.1 Philosophical Perspective Underpinning Data Analysis: Social Construction

Social construction is a philosophy that serves both epistemological and ontological understandings of the phenomenon studied. Both epistemology and ontology is central to the rigour of qualitative study (Denzin & Lincoln, 2005). While epistemology allows the researcher to have a clearer understanding of the forces that tacitly shape the knowledge claims, ontology allows the researcher to understand not only the dimension of "the nature of human being (subjectivity) and its relation to knowledge production", but also the dimension of "the nature of the object of study" (Kincheloe, 2005).

There are different approaches to social constructionism because it stems from, and is influenced by, diverse disciplines and intellectual traditions (Burr, 1995; Pearce, 1995). Hruby (2001) sees the social constructionism derives from three philosophical roots: sociological, postmodernist and neorealist. This study drew on a sociological approach which was influenced by the work of sociologists, Berger and Luckmann (1966) who wrote a book entitled, *The Social Construction of Reality*. Burr (1995) provided a useful summary of the work of Berger and Luckmann:

Berger and Luckmann drew upon the tradition of sociology of knowledge as well as theoretical perspectives of the social philosopher Alfred Schutz. Berger and Luckmann's treatise extended the sociology of knowledge beyond intellectual history to encompass "knowledge that guides conduct in everyday life"...When they asserted that "the sociology of knowledge" is concerned with the analysis of the social construction of reality, they prompted changing "the sociology of knowledge" to "social constructionism". This new conception highlighted processes of knowledge development (constructionism), while stressing the significance of human interaction (social) (p. 19).

By taking the view that knowledge is constructed through interaction between human beings within a social context, Leeds-Hurwitz (1995) argues that the sociological approach to social constructionism fosters the view of communication as "an inherently collaborative and cooperative activity" (Kellerman, 1992 as cited in Leeds-Hurwitz, 1995, p. 7). As such, adopting social constructionism from a sociological approach was particularly useful for investigating the characteristics and patterns of coordination resulting from communication changed through a TQM implementation.

May and Mumby (2005) consider social constructionism has become prominent in organisational communication studies. Shotter and Gergen (1994) advocate that social constructionism provides a blueprint for theorizing organisational communication because it accentuates the centrality of language, and it stresses the significance of social interaction processes. Several organisational communication scholars seem to agree. For instance, Cheney and Lair (2005) found the value of social constructionism lies in the analysis of organisations and organisational communication. More importantly, they make an important point for this study on the practicality of social constructionism for studying communication processes during organisational change: "We come to deeper understandings of the phenomena when we simultaneously consider the status of organizations as social actors and the very processes of organizing that create, maintain, and transform those organizations" (p. 58). Also, Leeds-Hurwitz (1995) found that social constructionism stresses the significance of language to construction processes valuable to organisational communication research.

Several researchers have adopted a social constructionism paradigm in their communication studies (e.g., Alvesson & Kärreman, 2000; Fairhurst & Putnam, 2004; Tracy, 2000). In one study, Sypher, McKinley, Ventsam, and Valdeavellano (2002)

asserted that a social constructionist perspective was the best way for them to capture the complexity of the social change process:

The social constructionist approach in the present project demanded an understanding of local knowledge...Such local knowledge, derived from interpreting, translating, discussing, and engaging in the lives of the study respondents, enhanced our (richness) understanding...With an understanding of the respondents' vocabularies and engagement in their worlds, our findings are more coherent, rich and connected...A social constructionist view suggests conclusions that are reflexive and interpretively flexible...(p. 202)

The above statement made by Sypher et al. well captures the key essences of social constructionism. Their statement not only illustrates what the researchers sought to achieve from adopting social constructionism as the epistemology in this study, but also that social constructionism could be used to serve both as an epistemological and an ontological understanding for the investigation of this study. The particular part of the above statement, “local knowledge, derived from interpreting, translating, discussing, and engaging in the lives of the study respondents” implies the inter-related nature of social constructionist epistemology and ontology. It signifies that the knowledge claimed was obtained by researchers through engaging with the object studied. This account, therefore, supports the claim previously made by several research scholars (e.g., Crotty, 1998; Hruby, 2001) that social constructionism not only serves an epistemological purpose, but also an ontological purpose. The notion that social constructionism serves both epistemological and ontological purpose was also taken up in this study.

Adopting the social constructionist ontology allowed the researcher to anticipate the ontological complexity involved in this study. Kincheloe (2005) viewed ontology as consisting of not one but two dimensions: “the nature of human being (subjectivity) and its relation to knowledge production”, and “the nature of the object of study”. Therefore, the ontology of this study consisted of (1) participants and their communication and interaction (in relation to characteristics and pattern of coordination and collaboration) and (2) the organisation studied.

Through the lens of social constructionist ontology, the researcher viewed the organisation studied as comprising fundamentally relational entities (O'Reilly, 1989) and the participants as interdependent actors who created and co-created meaning

though their interaction and communication. Understanding the ontology of the study in this way enabled the researcher to observe and interpret the shared meanings of local communication practice and coordination patterns; thereby, producing a knowledge bounded by localised practice and action (Anderson & Baym, 2004).

Despite serving as a useful epistemological and ontological understanding of this study, social constructionism has been accused of an “anything goes” relativism that can depoliticize constructs related to social (in) justice (Burr 1995). However, Gergen (1999) argued that social constructionism invites the researcher to discern various conceptions and to “generate alternative understandings of greater promise” (p. 40). Similarly, Crotty (1998) took a positive approach to the “anything goes” criticism by stating that the notion of social constructionism invites researchers to approach the object in a radical spirit of openness to its potential for new or richer meaning. The points made by Gergen (1999) and Crotty (1998) were supported in this study. As organisations are seen as fragmented (O’Reilly, 1989), viewing the organisation studied from multiple angles allows alternative views to co-exist and, therefore, the researcher was able to construct a more comprehensive understanding of the phenomenon studied. Nevertheless, this criticism was seen as a valuable reminder for the researcher to remain focused on the research purpose when analysing and interpreting data in order to minimize the chance for misinterpretation.

3.3.2 Data Analysis Procedures

This section discusses procedures involved in the study’s data analysis including the use of qualitative analysis software for data handling and management, Dey’s (1993) three steps of data analysis: describing, classifying and connecting, and the use of social construction as a lens for interpreting of the analysed data.

This study employed the qualitative analysis software package, Nvivo (QSR international Pty Ltd, Doncaster, Victoria, Australia) to assist with the data analysis. Given that the data analysis was an iterative process, Nvivo allowed the researcher to store, organise (i.e., develop trees of categories and subcategories; alter the coding; or create new categories) and retrieve the coded data systematically. However, to perform analysis using Nvivo, data from each source were prepared to be imported into Nvivo.

As Nvivo operates more efficiently and reliably in English-language-based documents, *the interview transcripts, participant observation field notes and document analysis records* were translated from Thai to English prior to the data analysis. All of the translation was reviewed by a native English speaker who has studied the Thai language for more than 10 years. The questionnaire survey data were processed and analysed using the statistical data analysis program, Statistical Package for Social Science (SPSS). The statistical findings of the questionnaire survey were described and interpreted; the key findings of the *questionnaire results* were summarised in a compatible format so that the results could be used to complement the qualitative data analysis performed in Nvivo.

Once all the data were stored in Nvivo, the researcher began the data analysis procedures following Dey's (1993) three steps of data analysis: describing, classifying, and connecting. Dey's three steps is an inductive approach to systematic data coding and analysis. The researcher started examining each data source one by one, beginning with the primary data source, interview transcripts. Dey's "describing" stage guided the researcher to review the data in order to gain an overview of the data collected. This process was helpful in that it allowed the researcher to focus at a macro level for an overall comprehension of each interview transcript and to make notes on key issues raised by interviewees. Normally, they were two types of answers found in interview transcripts: answers according to the question guidelines and answers to new or probing questions.

After reviewing all of the interview transcripts, the researcher began Dey's second step of "classifying" by performing an open-coding to create categories and sub-categories. The identification of these categories was an interpretative process because the researcher needed to identify whether each response or incident related to communicative attitudes and practices was influenced by TQM or not. Nevertheless, responses or incidents suggesting they were not influenced by TQM were not discarded, but stored under "not influenced by TQM" category and its sub-categories. To assist with consistency of coding and to improve the validity of the analysis, a "coding decision table" was developed based on key elements such as TQM principles and quality improvement activities.

Responses or incidents that explicitly and implicitly reflected the keywords appearing in the coding table were coded. For instance, the responses that were coded under “teamwork”, one of the TQM principles, may contain words other than “teamwork”, such as join, get together, working together, groups, meetings, workshops, we and us. The coding table was constantly updated with new, relevant words that emerged along the coding process. At the end of the coding process, the coding table was used to assist in the interpretation of data.

Additional coding categories, which were not previously identified, also emerged during the coding process. These emerging categories were placed under the category of “emerging issues”. Under this category were sub-categories such as difficulties, positive or negative views towards TQM implementation, and external factors that affected communicative practices. Responses and incidents that did not fit in any categories and/or were not able to be categorised at this stage were placed in the “not relevant” category, while the useful but not relevant responses or incidents were placed in the “unused” category. As the process of analysing the data was iterative, the use of Nvivo allowed the researcher to freely revisit all of the coding categories to alter or delete the coded responses or incidents, to re-categorise or merge sub-categories.

The final step of “connecting” was conducted once all the data including those from secondary data sources had been put through the first and second steps of “describing” and “classifying”. At the “connecting” step, the identified categories which were organised on a hierarchical basis (with each major category containing sub-categories and further sub-categories emerging from each of the sub-categories) from which lateral connections could now be made on their relations to *coordination*. The researcher found Dey’s (1993) “connecting” share similar to the method of “constant comparison” as the researcher needed to clarify the meaning of each category, to create sharp distinctions among them, and decide which were most important to the study. In short, this stage involved rearranging and refining categories as new insights (themes) emerged. The following paragraph describes the data analysis at the “connecting” stage.

All the responses and incidents, which were previously coded and categorised, were reviewed for their reflections upon characteristics coordination. There were also several cases that one response was viewed as potentially fitting into more than one characteristic of coordination. When this happened, all characteristics that were seen to potentially fit the response were compared to identify the best fit. If they fitted equally well, that particular response (or incident) was made available in both characteristics of coordination. The following paragraph provides one example of how the researcher interpreted and analysed one response obtained from one interviewee, a department director.

I think the key success [of implementing TQM activities] depends on participation, how well you *planned the process to allow your staff to participate and express their ideas or share their thoughts* in the quality improvement activities. Of course, we have to follow *a quality improvement roadmap* but the executions can be different...My success secret is to ensure my staff feel happy doing TQM. If you cannot have the willingness from the staff, the quality improvement will not last. So I make TQM activities engaging and fun...Doing TQM is about motivating people. There is no point to force them to do...

This response was coded in the first data analysis level under the topic coding of (1) leadership and (2) teamwork. For the secondary level of data analysis, the researcher reviewed this response and looked for a reflection(s) upon the characteristics of coordination. There were two reflections upon coordination in this response (in italic): (1) the role of manager in planning a process for staff participation (2) a quality road map as coordination mechanism. However, the first reflection seemed to be the main idea of this response. As such, this response was assigned to the role of a manager in facilitating coordination. In addition, this response also suggested the emerging theme on leadership and motivation (“...I make TQM activities engaging and fun...Doing TQM is about motivating people. There is no point to force them to do...”).

3.3.3 Social Construction: An Interpretative Framework for Final Interpretation and Presentation of Data

The above discussion on the data analysis suggests the various stages of the analysis and that each stage was fed back into one another for further analysis. Despite this, the themes emerged through these iterative data analysis procedures were still daunting, especially when attempting to present the findings logically and holistically

as required for theory building. One of the key reasons for the complexity of data was that TQM had already been embedded in the hospital's practices, and thus the boundary between TQM and non-TQM practice was not always clear. More importantly, the effects of each TQM principle were often related to one another, as well as demonstrating their various direct and indirect impacts on communicative attitudes and practices. As a result, it was difficult to make a clear observation and explanation on the emerging characteristics of coordination.

After several attempts to interpret and reinterpret the analysed data in order to develop a practical theory to explain the phenomenon studied, the philosophical ideas of social construction were found to be a useful guidance for further interpretation of the emerging themes. Social construction shifted the researcher's focus from *micro* level interpretations (relationships between direct and indirect effects of each TQM principle and its contribution to coordination outcomes) to *macro* level interpretations (relationships between TQM principles and their contribution to coordination outcomes). This particular approach was inspired not only by the notion of "social construction" which focuses on richness, shared meanings and relational entities (O'Reilly, 1989), but the social constructionist approach to case study (Chen & Pearce, 1995) which suggests the researcher should strive for comprehensiveness and interconnectedness, while recognising inconsistency and contradictions between relationships. Therefore, in the final interpretation, the emerging themes on the effect of TQM on communication and its outcomes on coordination were observed to link back to the role of management, or the "leadership" principle of TQM.

Once the study's key finding was settled on the "management" theme, the researcher decided to follow and explore further this key theme as a basis of writing up the findings. This means that the previous analysed data was reanalysed and reinterpreted on the basis of the role of management in relation to communication and coordination, and this had resulted in the emergence of new themes and sub-themes. Due to the fact many of these themes were derived primarily from the interview data, the researcher complemented these themes by secondary data sources including observation fieldnotes, document analysis records and questionnaire survey results, either to

support or question them. The existing literatures were also used to complement the data and analysis, and providing a theoretical basis to the write up for each chapter.

Parallel with the final data analysis and interpretation, the “write up” was also influenced by the principles of social construction which emphasises the use of narrative which includes details, examples of direct quotes, and paraphrases which mainly based on the interview responses and supplemented, where appropriate, by the secondary data source. Social constructionism also emphasises the notion of “shared reality”. The write up of the findings also included this notion into its narrative. Based on Berger and Luckmann (1966), the notion of reality “reality” is used to mean “knowledge”. Therefore, in this thesis, “shared reality” means “shared knowledge”. The use of this social construction language will be discussed in detail in chapter four to provide a basic understanding of the narrative style used in the presentation of the study’s findings. The procedures involved in the data analysis, interpretation and presentation of the study are summarised in Figure 3.4.

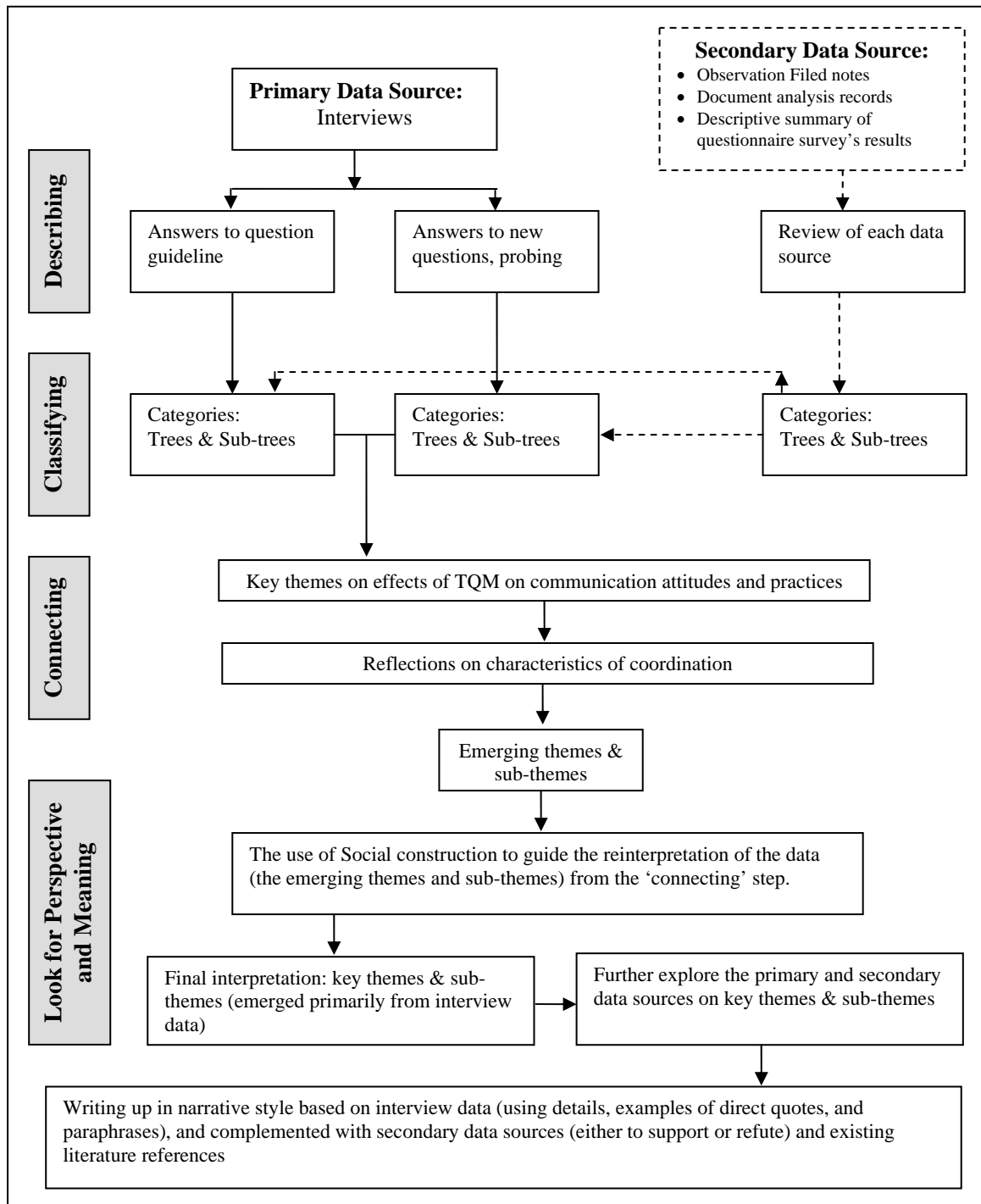


Figure 3.4: Summary of Procedures Involved in Data Analysis, Interpretation and Presentation of the Study

3.4 Rigour in the Study

Qualitative scholars seem to agree that “reliability”, “internal and external validity” and “generalizability” are inappropriate success measures for qualitative studies, given that qualitative researchers aim at generating rich insights into a particular case through attempting to understand the way the subjects of their research see and interpret their own world (e.g., Denzin & Lincoln, 2005; Guba & Lincoln, 1998). Although a set of alternative criteria for judging goodness or quality of qualitative inquiry including “trustworthiness”, “credibility”, “transferability”, “dependability”, “confirmability” and “authenticity” (Guba & Lincoln, 1998) was provided, some of these criteria are more important than others, depending on the philosophical and methodological premises within a particular study. The following discusses how each procedural element involved in this study, from designing the research strategies, conducting the study, analysing and interpreting the data to presenting the findings, was carefully planned and carried out with rigour.

3.4.1 Rigour in Designing the Research Strategies

Although the rationale and justification of the research design was discussed early in this chapter, this section provides a brief summary to demonstrate rigour achieved from maintaining the coherence between the research design (the research questions, the research strategy and data collection methods), and the analysis and philosophy underpinning the data analysis. Chen and Pearce (1995) saw criteria to evaluate the study influenced by social constructionism as involving specificity, contingency, complexity and reflexivity. These criteria were addressed in the design of this case study. A case study research methodology was selected because it allowed the researcher to thoroughly explore and obtain an understanding of the specific phenomenon studied. More importantly, with a single, embedded case design and multiple methods for data collection, the researcher was able to explore the multilayered and complex nature of the specific phenomenon under investigation. Finally, the broad conceptual framework was developed before the data collection and analysis to keep the researcher focused despite the complexity of the phenomenon.

3.4.2 Rigour in Conducting the Study

The most important strategies to enhance and maintain rigour take place during the actual conduct of the study itself (Morse & Richards, 2002), and this was especially true for this study. Thus, one important procedure undertaken to ensure the actual study was carried out effectively and efficiently was that of conducting a pilot study. The rehearsal and modifications made to the research procedures and instruments allowed the researcher to confidently and efficiently conduct the actual study. In addition, the use of purposive sampling technique allowed the researcher to seek valid representation to ensure that the data obtained were fruitful and reflected the phenomenon studied. For instance, the interviewees were selected because of their experience, knowledge and appropriate location in the organisation, as well as their willingness to participate. Using the purposive sampling technique together with a range of data collection methods allowed the researcher to identify bias or contradict over evidence. For instance, participants were asked, either formally during the interviews or informally in conversations during their free time to clarify some negative evidence and problems which were found by the researcher from the participant-observations or document reviews.

3.4.3 Rigour in Analysis and Interpretation of Data

Central to deepening the understanding of the social construction of reality is the belief that to understand this world of meaning, one must interpret it (Gergen, 1999). Alvesson and Skoldberg (2000, p. 78) suggested that good qualitative theory building should be “rich in points”, by which they mean interpretatively rich, as they continue: “Good research according to the criteria of interpretative richness thus enables a qualitatively new understanding of relevant fragments of social reality” (p. 279). In this study, the rich interpretation was obtained through pursuing the notion of bricolage and a researcher as “an interpretive-bricoleur” (Denzin & Lincoln, 2005). In addition to this, the use of the triangulation of data sources and the multiple interpretive frameworks also minimised the likelihood of misinterpretation as well as providing reasonable control over researcher biases.

3.4.4 Rigour in Presenting the Findings

The findings of this study were seen as a practical theory which was inductively derived from localised knowledge. The practical theory was presented in a narrative

style, and with the supporting responses and evidence obtained from the study. The rigour in presenting the findings was addressed through the use of the direct accounts of those being researched and by remaining as close to the social constructionism paradigm as possible. In other words, the findings should be presented with their purpose in mind, according to Denzin and Lincoln (1994) who suggested that the researcher needs to communicate to the audience not only the findings of the study but also the journey of discovery that has accompanied the inquiry.

Interpretation from the social constructionism is concerned with how social experience is created and given meaning regarding a specific phenomenon, and in a particular setting (Gergen, 1999). Chen and Pearce (1995, p. 149) saw that good theory building case studies of communication practice which are influenced by social constructionism are not meant to predict and control, but to enlighten and illuminate while acknowledging the complexity and contingency of communication practice. Several strategies and measures adopted to maintain rigour throughout the study procedures should carefully provide reassurance that the practical theory constructed in this study was well interpreted and reflected the communication experience of one organisation which had successfully implemented TQM.

In social constructionism, the practical theory developed is entirely contingent on field research and the insights that it generates (Cronen, 1995). The legitimacy for contribution of this practical theory can be found in its potentially transferability to the relevant literature addressed in the conceptual framework of this study, as Gergen (1999) noted:

Social constructionism focuses on the specific, the situational, and the particular and extrapolating these insights to seek transferability of ideas toward a redefinition of existing theoretical frameworks (p. 91).

Finally, the discussion of rigour in this study is concluded with Chen and Pearce (1995) whose account on a criterion in evaluating the quality of a case study had strongly influence in the craft of this case study: “The most beautiful case studies within social constructionism are those that enrich our conversation the most. They embody eternal joy, and yet rather than a timeless ‘joy forever’, they are enjoyed because they enable the conversation to move beyond them” (p. 151).

3.5 Methodological Limitations

Conducting a case study requires the willing co-operation of the participants. This study was limited to the extent to which people were willing to participate. As this study is constrained by time (approved by the hospital studied), financial resources, the busy working environment as well as the ethical requirement for participants' consent, the use of a more effective sampling strategy to develop representative sample such as a cross-section technique was limited. Nevertheless, the use of purposive sampling strategy for the data collection was found to provide good results—rich and insightful data were obtained from in-depth interviews and high response rate was obtained from questionnaire surveys.

Although the study had semi-structured, in-depth interviews as its primary data source, the use of these primary data sources underpinned the emergence of the key findings, given the rich and insightful data. This, however, means the use of secondary data sources was limited to either support or refute the key findings from the interview data. This was especially the case of the questionnaire survey data which was found to provide little support for the study's findings.

The researcher also adjusted her strategy for participant observation. In an attempt to make the least disturbance to participants, it was initially planned to keep minimum contacts and engagements with participants. However, as the researcher was allowed to participate in participants' working environments such as orientation days, training and workshops, conversations and relationships were naturally developed. This resulted in some informal conversations and discussions during coffee breaks or lunches. Some insightful pieces of information were documented as observation field notes while some were raised as probing questions during in-depth interviews. Although this strategy was not planned, it was found to enrich the data obtained for the study. As suggested by Yin (2003), the case study method has no standard to follow. Researchers must be flexible and attempt to glean information and insights wherever they find them. The freedom to search for whatever data an investigator deems important makes the success of any case study highly dependent on the alertness, flexibility and reflexiveness of researchers.

Another limitation was related to the in-depth interviews. Some interviewees' voices, particular those from the management level, were heard more than others in the interpretive finding chapters of this thesis. This was not a deliberate decision, but it was inevitably the case that some participants provided more insightful viewpoints and therefore, their accounts were more quotable than others. Besides providing useful information, the reason that responses of the participants from the management level were cited more than those from the operational level may result from the length of the interview sessions. The interviews with the management participants were generally longer than those from the operational level. This was because the researcher had to limit the interview with the operational participants to 30 minutes to respect the limited time given by their supervisors. The majority of data obtained during the data collection was in the Thai language, excepted for four respondents who were non-Thais and thus those interviews were conducted in English. To ensure proper words and expressions were used, the translation from Thai to English was mainly performed by the researcher, with the assistance of a native English speaker who has studied Thai for more than 10 years. However, it was possible that some expressions used may not be precisely match the interviewees' expressions.

Finally, a limitation was related to the use of social construction as the study's philosophical framework. Social constructionism was one of the key approaches used later in the study as it facilitated the interpretation and sense making of data. However, if social constructionism been adopted at the beginning, the design of the study could have corresponded more to the adopted philosophy, and the researcher could have been more reflective in her approach during the data collection. Nevertheless, as the data from the in-depth interviews were rich and insightful, and were complemented by participant observation and document analysis, the data obtained were sufficient for interpreting data through social construction's lens.

3.6 Conclusion

In an attempt to provide a logic and holistic discussion on the study's research methodology, this chapter began with a discussion on the rationale and details of the study's research approach, research design and research strategy used to address the

research aim and research question. It then provided detailed description of the procedures involved in the data collection and analysis as well as the use of social construction as the study's philosophy perspective to assist the final interpretation and presentation of the findings. This chapter also discussed key issues and considerations undertaken to ensure the study was carried out in a rigorous and ethical manner. The next chapter begins the presentation of the findings. It focuses on the first, emerging pattern of coordination which is observed to be facilitated by the role of the hospital's management's interpretation and construction of TQM reality.

Chapter 4

Management's Interpretation and Articulation of TQM Reality

This chapter and the following two chapters present the data analysis and interpretation culminating in the final conclusions in Chapter Seven. Prior to introducing the findings of this chapter, the study's findings from Chapter Four to Chapter Six will be outlined to provide a structure for presenting and discussing the findings in the remaining chapters.

4.1. Structure of the Presentation of the Study's Findings

The findings to be presented in this thesis are the result of the final analysis and interpretation of the data obtained from the study (for more details see section 3.3.3 and Figure 3.4 of Chapter Three) which indicate the significant influence of the hospital's management on TQM implementation and its effects on communication and coordination outcomes. This indicates that despite TQM consisting of several contributing principles, the *leadership* principle is the most influential principle. In fact, all other TQM principles of *common vision*, *customer focus*, *teamwork*, *problem solving*, *continuous improvement*, *empowerment* and *process focus* seem to be used as "a set of management practices" of TQM. This key finding thus suggests that the research question of the present study, *In what ways have the effect of TQM on communication attitudes and practices contributed to coordination?* is best addressed through the role of the hospital's management in TQM implementation.

As the final data analysis and interpretation was influenced by social construction, the role of the hospital's management in TQM implementation is described as the role of the hospital's management in constructing "TQM reality". According to Berger and Luckmann (1966, p. 24), "reality" means "knowledge" that has been constructed within particular social contexts that has particular meanings and experiences that shift organisational members out of their ordinary interpretations of everyday reality. Therefore, throughout the thesis, the term "**TQM reality**"⁴ is used when referring to "the knowledge of TQM", that participants take as "known" in the specific context of the hospital studied and use this knowledge to guide their conduct on a day-to-day basis (Berger & Luckmann, 1966). As there are multiple realities that co-exist within the same social context, it is possible to observe other realities, apart from TQM reality, within the hospital studies. Therefore, the term "**non-TQM reality (realities)**" is used when referring to other realities that are not influenced by TQM philosophy or knowledge. Examples of non-TQM realities are those realities influenced by national culture, organisational culture and professional values.

Parallel with the final data analysis and interpretation, the write up of the findings in this thesis was also influenced by the principles of social construction which emphasises the use of narrative which includes details, examples of direct quotes, and paraphrases which are mainly based on the interview responses supplemented, where appropriate, by the secondary data source including observation fieldnotes, document analysis records and questionnaire survey results. The existing literatures were also used to complement the data and analysis, and provide in a theoretical basis to the write up for each chapter.

Based from the evidence obtained, the role of management in constructing TQM reality has affected communication attitudes and practices which lead to the observation of three key emerging patterns of coordination. *This chapter* presents the role of management in interpreting and articulating TQM reality which results in the emergence of the first coordination pattern of "shared meaning and common purpose". *Chapter Five* presents the management's construction of a TQM influenced

⁴ This also applies to the term such as "customer reality" and "quality reality".

working environment which leads to the emergence of the second coordination pattern of “shared understanding”. *Chapter Six* presents the process of social interaction within the management’s constructed TQM reality which coordination is observed to emerge from “emotional experiences”.

This chapter discusses three main roles of management’s interpretation and articulation of TQM reality which were found to contribute to the emergence of the coordination pattern of “shared meaning and common purpose”. These roles are (1) introducing TQM as a business survival strategy, (2) communicating a shared common purpose, and (3) constructing the collective “customer focus” reality. The discussion now turns to the first role of management in introducing TQM as a business survival strategy.

4.2. Introducing TQM as a Business Survival Strategy

The management’s adoption of TQM as a business survival strategy during the country’s economic crisis was a crucial factor behind their employees’ cooperation and the hospital’s success in TQM implementation. In 1997, Thailand had faced a severe economic downturn which had an immediate impact on private hospitals. During the economic crisis, the numbers of patients attending private hospitals declined substantially, while activity in the public hospital increased (Waters, Saadah, & Pradhan, 2003). And, for those patients who still came to use the services of private hospitals, one manager of the hospital studied recalled that there was a change in their purchasing behaviour. This included decreased elective admissions, shortened length of stays and increased price sensitivity (Mng B w).

The dramatic decrease of patients had put all private hospitals in some degree of financial difficulty because much of the expansion of hospital capacity in Thailand has been fuelled with foreign capital, and this included the hospital studied. As documented in the hospital’s annual report (1998), the devaluation of the Thai currency (Baht) had substantially increased the costs of imported good, whereas the ability to recapture these costs was limited and thus, resulted in reduction of operating margins and decreased cash flow. In some private hospitals, the financial difficulty

was serious enough for them to either close down or for some of their facilities to close. As a result, many hospital employees were dismissed during the economic crisis (Mng B w).

Instead of using some cost-cutting operational strategies such as laying off employees, or reducing salaries and working hours, the management of the hospital studied saw its business's slow-down period as an opportunity to improve its internal operation and service quality so that when the economy recovered:

Not only our hospital could maintain a leading position, by the time the economic situation had recovered, we would have been in a position where our competitors find it's difficult to catch up (Mng B c).

Although the responses obtained did not provide the reason why the hospital chose to adopt TQM, as opposed to other forms of organisational change strategies, such as Organisational Development (OD) or Business Process Reengineering (BPR), it was likely to result from the voluntarily hospital accreditation program–Thailand (HA-Thai) which the hospital studied decided to join.

While the HA-Thai program seemed to have an orientation towards improving the quality service of hospitals for local Thai patients (Supachutikul, personal communication, October 4, 2004), the management of the hospital studied saw the program as a way to improve its quality to meet international quality standards after seeing the foreign market as a way to guarantee the hospital's long-term survival (The Hospital's Annual Report, 1998). That the hospital adopted TQM for the purpose of its business turn around strategy, not just complying with the Thai government's quality improvement scheme, was likely to be the reason behind the hospital's management strong commitment to TQM adoption and its success outcomes. Studies on TQM implementation found that early adopters tended to succeed in implementing TQM as they customised TQM practices for efficiency gains; whereas later adopters who adopted TQM through conformity pressures (e.g., from accreditation agencies) may gain legitimacy benefits and may find it is difficult to sustain its TQM program (e.g., Westphal, Gulati, & Shortell, 1997; Zbaracki, 1998).

Seeing TQM as a vehicle for the survival of the hospital, TQM was adopted through a top-down approach, and with a sense of urgency that required everyone to get involved. Although the top-down approach often creates resistance among organisational members (Hackman & Wageman, 1995), for the hospital studied, TQM was welcomed and supported by the hospital's staff members. At least four respondents from the operational level explicitly expressed their appreciation for this strategic decision. One of them said:

During the crisis my friend who worked in another hospital was laid off, another one was asked to stay home for a few months without pay. But me, I have a job and more work to do. We were very busy during the crisis because our hospital started doing TQM (Opt F p).

Studies found that the initial stage of introducing TQM to organisations is critical to TQM success given the employees a chance of resistance (e.g., Rago, 1996; Sitakalin, 2003). To successfully introduce TQM, therefore, requires the management to spend time, effort and resources to educate (Oakland, 2004) and persuade its staff to see the benefit of TQM (Fairhurst, 1993). This process is similar to Latour's (1987) notion of "translating interest" which suggests a negotiation process in which the explicit interests of the "enrolled" (e.g., the employee) can be translated so that in the end they become synonymous with the interests of "the enrollers" (e.g., the management). However, in the case of the hospital studied, the negotiation process for adopting TQM may not have been necessary as the hospital staff members, especially those from the operational level, seemed to share the "interest of survival" with the management. To them, they already experienced the benefit of TQM in providing them with job security.

Apart from sharing the same interest, the financial factor was also found to contribute to the hospital's TQM success. Although the hospital had its financial difficulties due to its foreign loans, the fact that the hospital belongs to a family who owns one of the largest banks in Thailand (The Hospital's Annual Report, 1997) provided a credit line for the hospital to extend its loan period as well as restructuring its debt. Having its financial difficulties settled meant the hospital's management could concentrate on achieving its business survival strategy, TQM. This was unlike other private hospitals which were forced to close down or change ownership. Suffering from financial difficulties also affected public hospitals. In a study of four public Thai hospitals

(Sitakalin, 2003), which voluntarily joined the same quality program as the studied hospital, the researcher listed dissatisfaction with the increased workload and lack of training budgets and resources as the major threats to implementing TQM.

Interestingly, despite successfully implementing TQM, some respondents were not so keen to credit the hospital's top-down approach. One senior manager from the TQM department said that when she was invited for a talk on TQM success, she would sometimes:

...feel a little awkward to see the surprised faces of people who learnt that our hospital used a top-down approach...With our success in implementing TQM, I think they expected to hear a word about bottom-up approach (Mng B ml).

Before saying this, *Mng B ml* showed some reluctance to point out that the hospital adopted the top-down approach. Another respondent from the operational level provided a similar response. Besides praising the hospital's management in leading the hospital to achieve "The three quality crown" (Opt B j) from both Thai and international quality accreditation authority (HA, JCIA, and ISO 9002, 14000) during its first five years of TQM implementation, *Mng B ml* felt the top-down approach used by the management was not an ideal approach for TQM which, according to another respondent from the operational level, was about:

...getting staff from the operational level to participate and share ideas, how they could improve their work or service within their working area so that they could work effectively or provide better service to the customers (Opt B j).

When asked from where *Opt B j* had this concept, she replied that it was from the hospital she worked at previously:

Our boss [in the previous hospital] initiated it. It really nice to see some innovative ideas about quality improvement from, say, a 50 year old technician make his "mobile service unit" from a broken table and patient trolley so he can visit each ward in the morning for little things need to be repaired. He found it was a waste of time and resource for people to submit request forms...and that I don't see in our [studied] hospital. Our management had a plan for us to do A, B, C and D. We just follow though...(Opt B j).

However, *Opt B j* also admitted that she had to quit her job at that hospital because it was closed down with financial difficulties. Obtaining a mixed message of the respondent's preferred bottom-up and the hospital's actual top-down approach, one may wonder know which approach was better. But the evidence obtained in this

study, though inadequate to address this issue, seemed to provide the findings that were inconsistent with previous studies on TQM success factors.

For instance, Mahmood (2000) argues that the large sized organisations tend to be less conducive to TQM, and Brown and Hendry (1997-1998) found that TQM tends to be successful in manufacturing industry more than in other types of business. In relation to health care organisations, reviewing studies of TQM implementation, Zabada et al. (1998) summarised key barriers to TQM including that health care organisations are inward-looking in nature, as they tend to focus more on the needs of care-givers and professionals rather than on the external customers; and that, in health care organisations, leadership style is based on command and control and hero/heroine models, rather than empowerment and the manager as coach.

Given the findings of this study revealed that a large-sized organisation did have a conducive culture and structure for success, TQM's success (or failure) is likely to be contingent upon each individual organisation and most importantly, upon the management's construction of TQM practice, rather than a prescribed top-down or bottom-up approach to TQM. To borrow from contingency perspective (Lawrence & Lorch 1967), it seems the hospital's management was able to produce a good "organisational fit" between capitalising on the uncertainty of the economic situation and the sense of urgency in survival the economic crisis as a way to secure employees' cooperation for its TQM initiative.

Nevertheless, being able to secure cooperation from the staff did not mean the management had a smooth TQM journey. One of the major difficulties with using the top-down approach was that it needs strong commitment from the management. Unlike the bottom-up approach where the staff are self-motivated and choose to implement TQM for its technical benefits (such as productivity, customer satisfaction, zero-defects), the hospital staff were willing to adopt TQM in the interest of survival, not the philosophy of TQM. As a result, the management had to spend considerable amount of time and resources not only in educating but also in motivating the staff to commit to TQM. With a considerable amount of time spent, one senior manager commented that whether choosing the top-down or bottom up approach for TQM adoption, it eventually takes a similar timeframe to effectively operate it:

...[with the top-down approach] we could adopt TQM at the organisation-wide level says within one year. But it took us a few years to educate our people to understand the real value of TQM...to gain their willingness and commitment...and to have a proper system to support TQM. Other hospitals may take longer time to adopt TQM because they need to educate their people and wait until their people see the real value of TQM. This process may take a few years but once their staff buy the idea [TQM], those hospital may not have to spend as much time and effort as us because their people had the willingness and tended to be more self-motivated (Mng B c).

Another problem mentioned by management was organisational inertia which occurred when manager loosened their control.

...we have to always push and motivate our staff. If we stop doing so, they become inactive...this was obvious once we had just been accredited...our people got exhausted from the preparation for the accreditation so we gave them a little break. After a while I found them in a hibernation mode and this took a lot of work to bring them back in the active mode...(Mng B c).

The responses obtained from senior management strongly support the significant “leadership” role in creating and sustaining the TQM working environment. Probably the most consistent findings in TQM literature from western countries as well as Thailand is the finding on “leadership” as the most important factor behind TQM’s success and failure (e.g., Fairhurst, 1993; Sitakalin, 2003; Supachutikul, 1998; Zorn et al., 2000). The following section discusses one of the important roles of the management in creating a new TQM working environment through internalising the shared common purpose which underpinned the new TQM working values.

4.3. Communicating a Shared Common Purpose

Internalising the shared common purpose was found to be the key strategy necessary for management to construct the shared meaning of TQM, and this strategy was particularly crucial for the top-down approach. In TQM literature, the concept of shared common purpose is often referred to as “common vision”, “common goal” or “consistency of purpose” in Deming’s (1992) term. More importantly, in relation to the management social construction context, the organisation's success is largely contingent upon the vision or mission driving the leadership as well as their ability to translate that vision to their constituencies (Bass, 1985; Bennis & Nanus, 1985; Fairhurst, 1993; Peters & Waterman, 1995).

In successfully uniting TQM as a sector of reality (Berger & Luckmann, 1966) with existing sectors of organisational reality, the hospital management was reported to have spent a lot of time and effort in communicating the shared common purpose, vision and mission throughout the hospital. Given the top-down approach, the vision, mission, and guiding principles were developed through a series of brainstorming sessions within the management team, consisting of the CEO, executive officials, and directors from all departments. Finally, they agreed on the vision, “world class service, world class medicine” and the mission, “We provide efficient world class healthcare with caring and compassion”. This mission statement was accompanied with eight guiding principles:

Table 4.1: The Hospital’s Guiding Principles

<ol style="list-style-type: none">1. We treat our patients as we would our family members and we embrace cultural diversity2. We are prudent, honest and ethical in all our dealings3. We work as a team4. We continually improve the quality of everything we do5. We maintain a happy environment with respect and mutual trust6. We encourage professional development and innovation through a constant process of learning7. We provide efficient healthcare to bring value to our internal and external customers8. We are good corporate citizens

(Source: The hospital’s annual report 2003)

In parallel with the creation of the vision and mission statement, an internal communication plan was developed to ensure the consistent communication of values, directions and expectations throughout the management level and all employees. The management was well aware of the importance of communication in internalising the shared vision and mission, as one senior manager put it:

To move toward our new vision and mission statement mean a change of our working culture...changing our way of working needs a great deal of communication. We make sure that we use the effective deployment of various means of communication from formal, informal and subliminal communication tool (Mng B c).

Besides being personally addressed by the CEO and other senior managers in sessions related to TQM activities such as workshops and conferences, the vision, mission and guiding principles were reinforced throughout the hospital in written forms such as the hospital’s publications, posters and banners displayed in conference rooms,

working units and other public areas. Every employee was asked to carry with them a pocket-sized card containing the hospital's vision, mission and guiding principles. Remembering these was made a policy issue. The effectiveness of communication and deployment of the hospital's vision, mission and guiding principles was assessed by senior management during their on-site visits. For instance, on a random basis, staff were asked to state the hospital's vision and mission statement.

In addition, the CEO maintained that management at all levels had a shared responsibility for communicating and spreading the hospital's vision and mission. It was not just the responsibility of the human resources or TQM department. Making everyone at the management level involved and sharing the communication task was one example of the team approach management style found throughout the study. Using the team approach, especially for communication, increased both the frequency and coverage of internalising the vision and mission. Every month, there was a coordinated, monthly cascade briefing on TQM progress within the administrative management team called "A Team", consisting of the senior management and divisional directors. In the meeting, information on progress as well as problems of TQM initiatives were brought up to the management team for review and/or revised its strategies or policies before communicating down to the operational level.

Another example was that the CEO ensured that a member of his senior management team shared responsibility for communicating the vision and mission through the development of each department's strategic plan. The director of each department hold a workshop with their work unit managers to set their goals and short and long term strategic directions to support the hospital's vision and mission statements. Cascading the vision and mission down this way made staff begin to question whether what they did had contributed to the organisation's vision and mission. One director noted:

The gradual cascading down from vision to mission to team and individual objectives allowed me and my staff to adjust our career goals to the hospital goals. It was not easy for some people. But we get them to start thinking about it and hope that they would start to perform and behave in a way that benefits our hospital's new direction (Mng F e).

However, not all managers were good at internalising the hospital's vision to their subordinates. Senge (1992) identified that personal power is not sufficient to influence transformational change. Rather, what is needed is individual charisma combined with an engaging vision, a set of personal values that the others would wish to emulate. House & Howell (1992) called this leadership characteristic "visionary leadership". The following paragraph revealed strategies in communicating and internalising vision used by a managerial staff member who demonstrated this style.

A divisional director commented:

It's not only about communicating the big picture [the hospital vision and mission] but it's about showing my staff how they could link their personal vision to the hospital vision. The key is to ensure the vision and mission of the hospital was translated to individual actions (Mng B t).

This director was applauded by not only his subordinates, but also by staff from other departments for his effective tactic in creating a shared individual and organisational vision which resulted in ready cooperation from his subordinates. He further said:

...the key is whatever we planned for them to do; we need to set achievements for them to keep them motivated. Doing TQM is about managing people, motivating people. There is no point to force them...Rather we need to approach the concept by showing them and convincing them what benefits they will get when they do it. ..We need to show a total obtainable vision for them so that they could look on and see where they are heading. They need to see their future along with the hospital's future (Mng B t).

Besides communication activities to internalise the shared vision and mission above, ongoing activities were organised to reinforce the already internalised vision and mission. For instance, an "annual quality day" was used as a venue for the quality showcase when one quality improvement project of each department was presented and the most outstanding project was awarded (Mng B w). The hospital also organised annually a "patient safety week" to highlight the message that, improving the quality of service also improved the quality of work (Observation fieldnote, October 21, 2004).

Several stories used to communicate this message were gathered during the study. One story was told in the patient safety week about a cleaner who forgot to empty one bin in the patient's room and quickly came back to empty the bin without

bothering to wear gloves. Unfortunately there were bacteria in the bin. Not only did she become infected, other nurses were infected, as well as a patient's relatives though the use of door knob, which the cleaner touched on her way out of the patient's room (Observation fieldnote, October 22, 2004). A similar story was heard during the new staff orientation but this story concerned a more dramatic HIV infection through a used needle. Despite a different version of stories, the message was powerful enough to convince the employees that they were not only doing quality improvement for the customer, but for themselves (Observation fieldnote, September 2, 2004).

The effectiveness of communicating vision, mission, and the guiding principles of the hospital was evident during the study. The results obtained from section A of the questionnaire survey showed that the information regarding "the goal of the organisation" was rated the most satisfactory out of the amount of received information (see Table 4.2 in grey column) by the respondents. More importantly, almost all of the interviewees were able to address the exact vision, mission and the key element of each guiding principles without requiring any memory aids.

Table 4.2: Questionnaire Survey Results Section A:
Satisfaction Index towards the Amount of Received Information

Information about...	Working Level			Working Section			TOTAL
	MNG	OPT	t- Value	Front	Back	t- Value	
A1: My performance in my job	21.13	20.07	1.4	20.34	20.48	-0.2	20.43
A2: what is expected from me in my job	21.67	22.32	-0.8	22.11	22.1	0	22.10
A3: Pay, benefits, and conditions	17.56	17.31	0.3	16.08	18.01	-2.0*	17.39
A4: Things that go wrong in my organization	16.88	16.34	0.6	16.21	16.67	-0.5	16.52
A5: Performance appraisal systems	17.21	17.37	-0.2	17.68	17.15	0.6	17.32
A6: How problems which I report in my job are dealt with	17.11	16.30	1.0	16.28	16.71	-0.5	16.57
A7: How decisions that affect my job are reached	15.85	15.16	0.8	14.54	15.79	-1.5	15.39
A8: Promotion opportunities	14.84	13.53	1.4	13.74	14.08	-0.4	13.97
A9: Staff development opportunities	18.68	18.40	0.3	18.65	18.43	0.2	18.50
A10: How my job contributes to the organization	19.02	18.41	0.7	18.58	18.63	-0.1	18.61
A11: Major management decisions	17.04	16.47	0.6	16.59	16.69	-0.1	16.66
A12: Important new service developments	18.49	19.06	-0.6	18.76	18.91	-0.2	18.86
A13: Improvements in services or how services are delivered	19.93	20.56	-0.7	20.07	20.48	-0.4	20.35
A14: The goals of the organization	22.02	22.43	-0.4	22.20	22.33	-0.1	22.29
A15: The total range of services offered by my organization	20.18	22.68	-1.9**	21.53	22.28	-0.7	22.05

* Significant at 0.05 level, **Significant at 0.1 level

However, what proved that the hospital had effective communication was that the staff seemed to have a substantial understanding of the message and were able to translate the message into actions. Many of the respondents including those from management often translated the hospital vision and mission into what they called “shared goal” (เป้าหมายร่วม – *Pao Mai Ruam*), which was commonly described as *providing the best quality service to satisfy the customers*. While the hospital official vision and mission statement were often addressed in a formal and rather cautious manner, many of the respondents looked comfortable and enthusiastic when talking about “the shared goal”.

Although “the shared goal” did not capture all of the factors in the vision, mission, and guiding principles, it reflected the core philosophy of TQM, customer focus. The data obtained were not sufficient to provide an understanding of how the official vision and mission was translated to the shared goal. Nevertheless, it seemed “the shared goal” was accepted by the management. One executive manager commented:

I am happy with their own version as long as it comes from their heart and that they commit to it...Maybe this [the shared goal] is our practical version, as it reflects our main purpose (Mng B w).

The same person also admitted that people often questioned the hospital’s ambitious vision statement. “They often asked me how to benchmark their world class practices?” Nevertheless, this executive affirmed that the hospital was doing everything it could, to be a world class hospital. It may possible that the term “world class” is associated to “quality” and thus, committing to the shared goal, *providing the best quality service to satisfy the customers* may lead the hospital to meet the world class standard.

In the TQM literature, a sense of common purpose is often referred to as “common vision”. However, in practice, the term “shared goal” was often used by both the management and operation respondents. Given that both terms are often used to mean “sharing a common purpose”, to maintain the original language used by the respondents, the term “shared goal” will be used throughout the report of the findings.

Among the major barriers to achieving coordination is the difficulty in agreeing on goals. To overcome this, a great deal of effort has to be invested into shared understanding (Huxham & Vangen, 2000), and this needs to be nurtured in the early stages of TQM adoption (Carley & Christie, 1992). These suggestions seemed to have been achieved by the hospital's management, given that emergence of the "shared goal" suggested that the staff members' own interpretation had occurred. Nevertheless, it seemed to occur within the boundary of the management's social construction of the hospital's vision, missions and goals.

By having the "shared goal"⁵, respondents from the operational level reported that they became clear about what they were expected to do in their jobs and what kind of working attitudes and behaviour would be rewarded. Examples of such responses included:

Unlike in the past, we are now working on the same direction. We know where we are heading. Our hospital aims to provide the best service and quality treatment. We need to impress them [customers] with our service so that they come back [e.g., annual check up] or tell their friends...this is the thing we focus on and it's our main policy (Opt F p).

It [the shared goal] provides a common picture for us as to where the hospital is heading; it connect my part of contribution to the big picture...the hospital also evaluate our performance on this...(Opt F l).

While terms such as *clear goals*, *picture or direction* were often used by the majority of respondents at the operational level, respondents who worked at the management level seemed to see the effect of the hospital's goals and vision on coordination as allowing them to *make decisions better* and *being able to reach consensus in decision making*⁶. According to TQM literature, the value of TQM's shared goals and vision lays in its ability to engage employees in meaningful ways in the decision making process (Dean & Bowen, 1994). However, in the hospital, employees who engaged in decision making tended to be ones who worked at the management level. This finding adds to the argument that the practice of TQM is contingent upon the management's

⁵ Although the hospital's shared goal is oriented towards TQM's customer focus principle, the specific effect of customer focus on coordination outcomes will be discussed in chapter six. This chapter focuses on the overall effect of the shared goal on coordination outcomes.

⁶ Most of the examples obtained for decision makings were principally related to the hospital's 'customer oriented' goals. Therefore, the examples will be addressed in the chapter six.

interpretation (Kelemen, 2000). More specifically, that the management of the hospital seemed to hold most power in decision making was a result of the interpretation of TQM from its top-down approach.

Schein (1993) saw “organizational integration, coordination and learning are hindered most by variations in the hierarchical subcultures because of the myth that all managers speak the same language” (p. 50). However, the influence of the TQM notion of organisation-wide integration (Deming, 1992) was found to be particularly useful for nurturing coordination within the top-down approach, as the management was obliged to ensure that the hospital’s vision, goals and missions were communicated at the hospital-wide level. In TQM literature, the important role of the operational or front-line task force is emphasised because they are ones who actually implement the quality improvement activities (Fairhurst, 1993).

Evidence obtained in the study also suggests that that when the operational staff shared common ground with the management, they became more receptive to the hospital’s key messages. This point was brought up by some managers who observed that their subordinates tended to be “receptive” to messages relating to the shared goal. One manager commented:

Our staff know we are heading to be world class. They know our mission. So when we communicate about quality they are receptive to our message...it’s the thing they know we emphasise (Mng B ml).

Although respondents at the operational level did not use the word “receptive” in their responses, some of them found the message related to quality improvement were “the-must-listen messages” (Opt F j) and “important to my job” (Opt F k). Detert, Schroeder and Muriel (2000) saw that the TQM value of shared visions and goals implies a belief in the power of coordination. Although sharing goals and visions alone could not leads to coordination, it allowed the hospital’s staff, especially the operation staff who made up the largest numbers of the hospital’s employees, to develop a common knowledge of the hospital’s vision, missions and goals. This was in contrast to the past where the hospital’s vision, missions and goals were seen as a part of the hospital’s strategic business directions and often only shared within the management level.

4.4. Constructing the Collective ‘Customer Focus’ Reality⁷

This section focuses on a specific aspect on the management articulation of the TQM principle of *customer focus*. This collective customer focus reality was seen in this study as a social bond allowing staff within the hospital to communicatively create and sustain their coordinative working relationships. This finding illuminates the notion of “social coordination” which considers that a social order becomes possible when a group of people has the collective ability to coordinate their actions (Couch, 1984). This collective ability derives from the realisation of a shared perspective, called a “common ground” (Clark & Brennan, 1991), in interaction within the group.

The key findings of this chapter are based on two emerging themes that contributed to the management’s construction of the collective customer focus reality: (1) the management’s interpretation and articulation of TQM reality and (2) the congruence of the constructed TQM reality and non-TQM realities within the studied hospital. To provide clarity, these two themes will be discussed separately, despite a simultaneous interaction.

However, prior to this, the following discusses the initial data analysis process which provided guidance for the further data analysis and interpretation of the findings on the two episodes. The significant role of the TQM principle of *customer focus* initially emerged from observation of the frequencies counted from the analysed responses on interaction between TQM principles and incidents or activities that related to interpersonal communication and reciprocal relationships. The observed frequencies provided two important indications for further data analysis on patterns of coordination.

The first indication was the interplay between the highest and second highest frequencies of the responses quoted on TQM’s *leadership* and *customer focus* principle respectively. It was found that more than half of the responses on the *leadership* principle reflected some aspects of the *customer focus* principle, and vice

⁷ It is important to note that, the finding of this episode emerged from the term ‘customer’ which was made by respondents in reference to TQM incidents and activities, as well as to those not related to TQM, given that they were seen to affect TQM implementation of the hospital studied.

versa. Examples of responses on TQM's leadership and customer focus principle were:

I [a director] always tell my staff members that we need to work together if we are to provide the quality service to customers. (reflected the leadership principle)

We have support from management if we propose plans or activities that will benefit customers. (reflected the customer focus principle)

This finding highlights the important role of management in the construction of TQM reality. To borrow a drama-based approach (Cairns & Beech, 2003) to social construction, in this study, management can be seen as "social producers", who articulated the attainment of "customer focus" among their subordinates, who were seen as "social actors". Together, producers and actors co-created and co-constructed their collective focus on customers.

The second indication was that, once all the analysed responses were revisited, it was found that some of the responses from other TQM principles were also made in reference to the *customer focus* principle. Frequencies of responses that reflected the *customer focus* principle are shown in Table 4.3, along with some examples of the responses.

Table 4.3: Frequencies of the Initial Data Analysis⁸

TQM principle	Total frequency	Frequency reflecting customer focus	Example of response*
Leadership	34	19	We [management] need to listen to our operations people because they spend their time with customers more than us.
Customer focus	27	27	We need to coordinate within our team, who are responsible for talking with customers. Otherwise customers will have too many phone calls from us and cause confusion.
Problem solving	16	10	We get together to solve problems with the same focus on customers.
Teamwork	19	12	When customers come to our hospital they have to go through several procedures. Staff members at each procedure are serving the same customer.
Empowerment	15	7	They always keep me informed as they know customers will contact me first.
Continuous improvement	14	8	We always discuss formally and informally on how can we improve our services to better serve our customers.
Common vision	10	4	We shared a common goal in providing the best service for customers.
Process focus	6	2	When customers complain about our staff manner, we did not punish or blame the staff. Rather, we fixed our system.

The reflection of the *customer focus* principle in the responses obtained for other TQM principles indicates that ‘customers’ was placed at the centre of incidents or activities mentioned by respondents. Figure 4.1 shows their interrelated relationships.

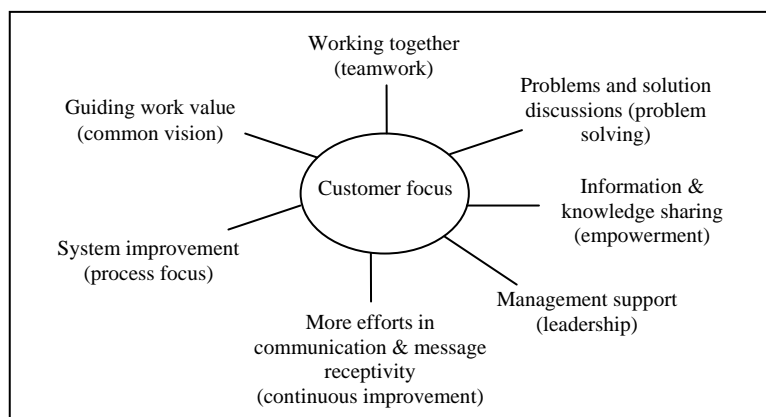


Figure 4.1: The Link between the Customer Focus Principle and Other TQM Principles

These inter-relationships provide a useful groundwork for further data analysis of the effects of TQM on communication and coordination. However, it is important to note

⁸ Frequencies were used in this study to provide guidance for further data analysis and interpretation.

that the boundary between TQM and non-TQM realities was not always clear. This means that, while some responses obtained suggested a direct effect from TQM reality, other responses were difficult to make a claim as to whether they were indirectly affected by TQM reality or, were influenced by other realities. This is especially the case of individuals' own characteristics, personalities, competencies, professional background and national and cultural background. In addition, it was also possible that the respondents were influenced by both TQM and non-TQM realities.

Whilst it is important to understand the contextual environment (non-TQM realities) of the knowledge sought (within TQM reality), this study saw that it was crucial that attention be paid to uncover the knowledge sought within its context of the inquiry of the study, TQM reality. Therefore, the findings to be presented in this chapter were constructed from the evidence that emerged within the TQM reality. As for some evidence which displayed the influence from non-TQM realities, this evidence was seen to interact within TQM reality and thus, will be addressed in this chapter as a part of the hospital's TQM reality. Having provided the initial data analysis and its findings which were used as a backdrop for the data analysis and interpretation of the key finding of this chapter, the discussion now turns to the two key themes of this section.

4.4.1. The Management's Interpretation and Articulation of TQM Reality

There was some evidence suggesting that an association of customer focus between some of hospital's non-TQM realities and TQM's reality was likely to result from management's interpretation. Some respondents from the management level tended to emphasise TQM's *customer focus* principle, specifically when they referred to TQM as the whole concept. Among responses that reflected this management attitude, one useful response was obtained during the extra time of interview when the researcher asked additional questions outside the question guidelines. When asked why many hospitals were still struggling with TQM, a department manager observed that these hospitals tended to emphasise technical elements of TQM, not patients who are the core idea of TQM; as she commented:

It [TQM success] involves a lot of factors...strong management, commitment, time, mindset and training...I think they [struggling hospitals] seemed to make TQM complicated...got so carried away with those fancy technical terms and

so anxious on getting the right strategy for achieving TQM and achieving the accreditation...TQM is just a simple term, nothing new, really...People who chose to work here already have a mindset and compassion for patients and this is good enough for TQM. From what I have discussed with other hospitals, I felt that they tended to focus on technical elements such as setting indicators, learning new terms, and statistical measures. They tended to focus on the technical side, and so they forgot the core idea of TQM which is actually already what they do on a daily basis, serving the patients...if they focus on how could they serve patients better then they implement TQM already...those technical things are just tools (Mng B ml).

Similarly, another divisional director saw the core idea of TQM lay in customer satisfaction. According to him:

To successfully adopt the concept, we need to understand the concept, find the concept valuable and try to approach it in a simple way. When we did TQM and HA [Hospital Accreditation], I didn't use those terms [TQM and HA] with my staff. Rather, when I talked with them for the first time about this thing [TQM and HA], I said to them that, in our daily operations, we need to have a working standard to ensure we carry our tasks professionally and being to provide quality service to our customers. Then I slowly introduced our plan for working within a quality standard...The first activity that I organised was a satisfaction survey. The core idea of quality is to have customer satisfaction...(Mng B t).

Besides suggesting that the *customer focus* principle took centre stage in their interpretation of TQM, these two responses contained the view that TQM was in fact a shared concept in the studied hospital. While the former respondent saw TQM as “nothing new”, “TQM is just a simple term” and “...do on a daily basis”, the latter respondent tried to “approach it [TQM] in a simple way” by using customers as a part of his introduction of TQM. These responses seemed to suggest relationships between the management's interpretation of TQM and their observation of the links between TQM and the hospital's existing realities. More importantly, the fact that the latter respondent introduced TQM as “a set of standards to ensure their tasks in the daily operation to be carried out professionally...” was an effort to simplify the notion of TQM to be clear, yet relevant in the eyes of his subordinates.

The need to interpret events in relation to the existing context has been identified as an important element in social construction of the organisation's environment (Ring & Van de Ven, 1989) and in organisational change (Pettigrew, Woodman, & Cameron, 2001). The evidence obtained, however, did not provide a clear understanding whether it was their intention to interpret and construct TQM in a way that was

harmonious with the hospital's existing realities, or whether it was the influence of the hospital's existing realities that bore on management's interpretation and construction of TQM reality. Either way, both views seemed to reflect the social construction process where the management as "social actors" (Berger & Luckmann, 1966) develop intersubjectivity realities by incorporating the external, objective reality into a collective, subjective one.

Literature on organisational change including TQM often discusses the powerful role of leaders in organisational change (e.g., Deal & Kennedy, 1982; Peters & Waterman, 1995). The finding of this chapter supports this view and more specifically, it saw that the collective reality which emerged as a result of organisational change through TQM lay in the influence of communication made by management. This is similar to Grønn's (1983) notion that "talk" does the work of leadership because talk is the resource used to get others to act.

A related notion in the communication-based social construction approach of Hardin and Higgins (1995) saw the emergence of this new reality as resulting from the influence of communication on the perceiver's view of reality. Salancik and Pfeffer (1978) used the term, "articulation", to describe when employees' job attitudes and task behaviours are socially constructed, largely based on normative and informational cues, communicated and made salient to the employee by significant others in the work environment. The following provides evidence obtained specifically in regards to the management's expression of customer focus. Two key themes of the management's expression of customer focus are to be addressed in this section: (1) customer focus as management's guiding value and (2) customer focus as management's coordination mechanism.

4.4.1.1. Customer Focus as a Management's Guiding Value

This theme focuses on the role of customer focus in the management's daily routines. Because it was difficult to clearly identify the boundary of the influence of TQM and non-TQM reality, the finding of this section was treated as one section of the management reality where the "customer" was the priority of management. Although "customer" was officially nominated only in two of the eight guiding principles of the hospital (see Table 4.1), it was observed that some of management's responses were

made in reference to other guiding principles of the studied hospital, suggesting management's commitment to customers.

Among responses that reflect management's commitment to customers, is the one obtained from a senior manager who confidently said that the fact that the hospital was driven by customers revealed that the top management held a strong commitment to customers:

We are a patient-focus hospital. We may have a structure and a system that looked complicated and hierarchical, but we see them as our means to provide a quality medical service to keep our customers satisfied. We have a strong belief that "patients" is the best answer for managing hospitals. If we focus on patients then everything we do is linked back to our goal which centre on patients and that should lead to a good outcome. If we focus on financial outcomes, it won't last very long. This is why here, customers lead our every move...it's not easy to do...lots and lots of problems to solve constantly...but we are pushing through. Nothing is better than staying focused (Mng B c).

This view is also consistent with ones obtained from a divisional director whose responses also revealed the key motivation behind management's commitment to customers, aiming to achieve the hospital's mission:

Our mission is to provide efficient world class healthcare with caring and compassion. This mission has been communicated to all staffs so they all know that their main job is to provide the best medical treatment and service. We are not claiming that customers will completely be cured but at least they should be confident that when they come for a treatment at our hospital they will have the best care and service from us...It's our goal that we aim to achieve and we always tell our staffs that to reach this vision, we need to work together hand-in-hand, for the sake of our customers (Mng B w).

Although the relationship between aiming to achieve the hospital's mission and committing to customers can be seen as simple motivational logic, what seemed to allow the hospital to capitalise on this motivational logic was the *realisation* of the notion of "working together hand-in-hand", as stated in the above response, and the *actual application* of such a notion. The same staff member stressed the need to work closely with the marketing department because he wanted to ensure that the hospital's marketing campaigns were appropriate and ethical, according to him:

I work with our marketing people too. Although my main responsibility is to look after the management and medical area, we need to ensure that they [marketing people] are on the same direction because, when things go wrong, it becomes my problem too, no matter what! Marketing cannot over claim or over promise our medical treatments and services that we have to offer. So I'm

always involved and work closely with them...I respect them. They are compassionate marketers. It's our intention that our marketing is conducted ethically and compassionately. [Would it make them feel like being controlled?] I don't think so. They seem to like me [he smiled] No, not at all. I respect them as professional marketers and they respect me for my knowledge in medical areas...They want my input for their marketing campaigns. [Could you provide examples?] Launching one marketing campaign on new medical equipments such as MRI Scan needs to be coincided with the medical treatment area. I can give them information such as the timeframe that the medical people need to be ready to provide service; they cannot just put on ad campaigns once they saw the machine has just arrived. Our medical people need some "trial" period, and we need to allocate people as well. We don't want a situation when medical people are not ready but customers are at our door step (Mng B c).

The close working relationship between this senior manager and the marketing division reflected was consistent with the comment on strategic marketing mentioned by this respondent and a middle manager from the marketing department respectively:

We emphasise word-of-mouth [communication]. We find it's a very valuable communication tool...We see our hospital as our main billboard in itself. So we need to do our best on the spot to create the best possible impression. This way of communication may take some times but when we have it, it tends to last very long. It's evidence-based marketing. We are not doing like other hospitals which use a lot of advertising. We believe in creating best service and value from within. So what we communicate with them is to ask them to come and try our service (Mng B c).

Our management people focus on creating good word of mouth communication. They focus on developing and creating good medical service. We hope that customers who came in and experienced it would have a good impression and their families and friends about our service...what we do is more like the experiential marketing strategy...(Mng B ku).

While the senior staff member used the term "evidence-based marketing" which seemed to reflect technical TQM language such as "management-by-fact" and "incident review" and that the manager from the marketing department used the original marketing term, "experiential marketing", both shared the customer-oriented notion.

These responses quoted above revealed the linkage between the customer focus as management's guiding value, and the second and third of the hospital's guiding values: "we work as a team" and "we are prudent, honest and ethical in all our dealings". The observation during the time of the study and from the evidence obtained showed consistency in the hospital's intention to work together to ensure that the customers were treated well and ethically. This also showed in the review of the

hospital's marketing and promotional materials of the year 2003 which suggested that the hospital often used its national and international quality accreditation certifications (HA, JCIA, and ISO9000/14000) as the key communication message, instead of over-claiming or glossy marketing language.

The hospital's enthusiasm for building and maintaining good relationships with customers was also apparent from the hospital's staff members. One of the responses obtained that reflected this strong commitment came from a senior manager who used a "marriage" metaphor to describe the hospital's relationships with customer.

I see our relationship with customers in four stages. The first stage we introduce ourselves of who we are and what we do. Second we get to know each other. It's like having a date. We may go out to see them through our activities, road show. Third, we get engaged. They became our first customers. The final stage is that we get married. They stay loyal to us and we do our best to keep them happy and satisfied...each stage of relationship requires a different way of communication. Then our customers from each country have a different stage of relationship. Thais are in the marriage stage, they know use well...for countries that we just begin our relationship, we send our doctors to give lectures and all sort of medical collaboration (Mng B c).

However, these positive findings should be taken only within the hospital's own interpretation of "customer satisfaction". This was because when customer satisfaction was interpreted from the hospital's external customers, some contradictions were found to emerge from the evidence obtained, specifically in regard to the hospital's third guiding value, "we are prudent, honest and ethical in all our dealings".

It is important to note that comments from external customers were treated as the external reality outside the context of the study.⁹ However, this external reality was found to affect the interpersonal relationship between frontline staff members and thus it was decided to be included in this study. The findings obtained suggested that that, while the hospital tended to interpret customer satisfaction from its quality service point of view, some of its customers seemed to include the cost of treatment and services into their determination of the level of their satisfaction. The result of these

⁹ This study was proposed to and approved by the hospital studied for the internal investigation regarding the effect of TQM on communication and coordination and collaboration. Thus, the view from the hospital's external stakeholders was excluded from the formal data collection.

different interpretations was found to have an indirect, negative impact on the hospital's coordination, specifically in relation to interpersonal relationship between frontline staff members.

The "price" issue was one of the most complained of issues made by customers of the hospital studied. Evidence obtained from the customer satisfaction surveys (The hospital's customer satisfaction survey report year 1999-2002) and from the responses obtained from frontline staff members shared a similar issue on the customers commented on high prices. One manager commented that "...our customers, especially Thai customers are very price sensitive and they expect top value for money" (Mng B v).

Although the high cost or expense was constantly mentioned by respondents as examples of customer complaints, the researcher instead chose to explore other complainant issues that related to communication practices such as language difficulties and misunderstanding. However, after the iterative data analysis process, the high cost issue which was previously left in a not-relevant to the study context category was found to have a linkage to the hospital's internal pattern of coordination, specifically among staff members at the frontline. The findings obtained revealed that some frontline staff members reported their stress and frustration from dealing with the unpleasant manner of some dissatisfied customers over the cost of treatment. More importantly, this problem created a conflict between staff members from different departments in the front office. For instance, one customer service officer spoke of a conflict she had with some cashier staff members who tried to send complaining customers to customer service, according to her:

They [cashiers] think that it is our job to deal with customers who have any trouble with the hospital. When some customers saw the bill and got upset with the cost, instead of trying to deal and explain to that customers, they sent the customer to us...some times I feel our job is like garbage handlers [กระโถนห้องพระโรง - *Ka-thon-Tong-Pro-Long*], you know. It's really frustrating when we are so busy serving customers and they put us through this thing (Opt F p).

Other respondents said that although they had to deal with the customer complaints on high cost, they felt that it was out of their power to solve this problem for the customers, according to one respondent:

[On customers complaining of high cost bills] Our job is to take their complaint to the management. Some customers wrote it [in a customer feedback form] and some made their complaint verbally. However, we usually wrote down what they said in the hospital's customer complaint form and submitted it to the TQM division on behalf of the customers...we really want to help but this issue is so out of our hands...but our boss understand this point. They know that it isn't the problem caused by the frontline staff members...knowing this has taken pressure off our shoulders (Opt F c).

One management staff member shared a similar view that, while complaints on high cost were not desirable, to him, it was better than those made on the hospital's service.

What concerns me more is the customers who had a bad experience from our service or, our service did not live up to their expectation. To me, they are very serious issues and we need to take immediate actions...For the cost, I think we have a reasonable price given that we provided an international quality standard. Our price is actually the same level at some other private hospitals that had been accredited only at the national level...let's put it this way, we are aware of this issue and we are monitoring it...but for me, especially, in my position, providing the best possible quality care and service is our main focus (Mng F p).

Despite that the evidence obtained in this study confirmed that the strong commitment of hospital in providing its quality service to customers, the customers' dissatisfaction and complaints on high cost are likely to continue because of the contradiction between the version of "customer satisfaction" interpretation between the hospital studied and the customers.

Another issue that related to the ambiguity of the interpretation of "customer satisfaction" was found in a response obtained from a divisional director who admitted that early in the hospital's TQM adoption, some of the hospital's staff members raised a concern regarding the professional ethic in pleasing patients and the compromising of medical quality with customer satisfaction.

I always tell our staff that although it is important to keep our customer happy but we have to remember that while they are customers, they are also patients. They seek medical treatment and we cannot spoil them just to give them a temporary happy moment. We want them to have long term health which is sure to make them happy. [Could you provide some examples?], the most often asked question from them is can they bring their pets to stay with them in their room? We cannot please them on that. First, for the sake of other patients who may feel uncomfortable to see pets in the hospital. Second, for their own health and pet's health. Although we understand that they look after their pet well but they have to understand that the pet is fragile and that may be at risk in the hospital environment...(Mng B w).

Although the problem in the above response was solved, it reinforced the crucial role of ongoing communication during the construction of TQM reality and the articulation of the hospital's mission, vision and key guiding values because these key messages assisted the interpretation of the hospital staff members, specifically those at the operational level. Fairhurst (1993) found that in some circumstances or situations when the information or interpretation cues are absent; individuals tend to rely on their existing realities to assist with their interpretation and this may create conflict or misunderstanding in communication.

Thus, despite some negative feedback on the interpretation of "customer satisfaction" found in this study, the role of the hospital's management in consistently reinforcing the customer focus value of the TQM reality, specifically through their espousal of the hospital's guiding values, was found to have a significant contribution to the alignment of attitudes and the behaviour of the hospital staff members. The commitment to the customer focus value was also found to be made in relation to the hospital's future strategic direction as revealed by two respondents from the management level.

We are now trying to move the concept of customer focus to the concept of patient safety which we make it clear that we care about. The patient and safety is also a broad quality than customer focus. Safety means we protect the patient from the hospital environment, protecting the patient from doctor or nurse error. But we still call TQM department as this stage. Depends on how well we go. We may change the name to something about patient safety (Mng F p).

In this few years, the hospital is heading toward CRM [Customer relationship management]. Establishing and maintaining our relationship with customer is our priority. That's why they [management] hired my boss. They want to merge our hospital with hotel service. We want to have a signature service that differentiates ourselves from others [private hospitals]. But we also have process and policy to follow as our core value is medical treatment and we cannot compromise medical quality (Mng F j).

These two responses indicated that the hospital not only has a long-term commitment to customers, it also has a plan to approach the customer focus concept in a more holistic way. This was because, while the first response focused more on the medical aspect, the second response focused on the service and relationship aspect.

4.4.1.2. Customer Focus as a Management Coordination Mechanism

The “customer focus” terms of *customer satisfaction* and *customer expectation*, and customer related term of *accreditation* were found to serve as management coordination mechanism in two forms of “motivation” and “control” in order to obtain subordinates’ cooperation and participation in quality improvement activities. One middle manager raised the idea of the use of customer satisfaction as a motivation to get her staff members involved in quality improvement activities:

I find my staff members become very excited when, in the meeting, I reported the result of customer satisfaction survey or monthly customer feedback...so I often bring this issue early in the meeting to get their attention. It’s a good way to introduce new policies or procedures on quality improvement after the customer satisfaction report...they [her staff members] really pay attention and ask lots and lots of questions...showing me a sign that they want to take on board...but when they heard negative customer feedback, the room was getting a bit of tense (Mng B j).

When asked to share her practice on the use of customer satisfaction as a motivation, she replied it would be best for the researcher to meet and interview, in her word, “the master” (Mng B j). She then made an appointment for the researcher to interview *Mng B t*, whom her colleagues and herself admired for his division’s TQM implementation. According to *Mng B j*, she found the strategy to executing TQM of *Mng B t* was “practical”.

The interview with *Mng B t* suggested that it was his own leadership skills that benefited the construction of TQM reality within his division. His approach to TQM was different to that of the hospital’s which tended to, “pre-assign tasks for us to do this and that. Doing this way is possible but we [management] need to always monitor them [subordinates]...” (Mng B t). He saw the hospital required close supervision and thus he found self-motivation was the key to implement TQM. According to him:

People are motivated by something. There are always ways to motivate them. I don’t think it’s a good thing to tell them [subordinates] to do A so that we can have B. They may not want to do A because they don’t need to have B, or because they can not see why B is good for them...we need to approach TQM by showing them and convincing them what benefits they will get when they do it. It’s about managing and motivating people to be successful in doing it (Mng B t).

This divisional director saw customer satisfaction as a way to motivate his staff members to participate in TQM. Therefore, he began the TQM program with a customer satisfaction survey as he commented that it was:

...actually my planned tactic to get them started. I knew that the result should be good because our hospital's standard is already good...Once they did the survey and got good feedback, they felt motivated to do it better, and they can see the benefit and good feeling to obtain the good outcome. So they want to do more without being forced to do (Mng B t).

Besides seeing that external customer satisfaction was the motivation to his subordinates, he was also concerned about his own staff members' satisfaction, as he stressed:

My success secret is to feel happy in doing TQM. If you cannot have the staff members' satisfaction or willingness towards the concept it will not last long...or management need to work very very hard on monitoring them (Mng B t).

Although his way of motivating staff members to engage in TQM was seen as effective, very few managers appeared to have this skill. Rather, the data obtained suggested that many still opted for the "control" approach when they needed cooperation and involvement from staff members. Nevertheless, it was found that TQM allowed managers to have implicit ways of doing so. One of the most insightful accounts was obtained from an executive official who commented that:

"Customer satisfaction" is the most important success indicator for every quality improvement program. Having HA and JCIA certification means we reassure our customers that we provide healthcare services that meet both national [HA] and international standard [JCIA]...so achieving the accreditation and re-accreditation is a very good reason for senior management to tell our staff to do certain things...when my staff see that what they have to do is a way to achieve the accreditation, they will do accordingly...This means that they will have to discuss with their co-workers to make sure their tasks are completed...More importantly, my staff know that achieving the accreditation means they need to improve their work performance so they could produce good outcomes...Now we focus on monitoring their work outcomes, rather than keep our eyes on their every move...They know the management team is watching for the outcome. I think this is why communication is improved after TQM. When they want good outcomes, they try to work in team and try every way to communicate within and between teams...(Mng B c).

Besides suggesting that *customer satisfaction* and *accreditation* was used as the reason to gain cooperation from the hospital staff, what makes this comment interesting was that it was obtained from this respondent who was observed, from his

interaction with his colleagues during the time of the study as well as from some the interview' responses, to be open-minded, friendly, approachable, and well-respected for his humble and easy going personality. Although the data obtained did not allow uncovering the contradiction of this response, it was likely that using a motivational approach to coordination may be difficult for a large and complex organisation like the studied hospital, and that using the control approach was likely to be a more appropriate strategy.

Seeing that the motivational approach seemed to work well at one division may raise ones' hope that the motivational approach may work at the hospital-wide scale if the motivational approach was implemented in every division and department of the hospital. However, it may not be the case, especially for the studied hospital. This was because the responses obtained suggesting that the bureaucratic, management style was still a common practice among managers.

Many managers often commented that adhering to the hospital's rules and policies was the priority and that the notion of customer satisfaction was found to be used in a control mode. The following comments are examples of such responses:

I follow the process and system. We need to ensure that steps 1, 2, 3, 4, and 5 are completed because this is the way to maintain our quality standard and customer satisfaction level...and this is why I have a lot of communication with my staff so that they could follow the process...I believe in the system because it can keep on running even when we put new staff members in (Mng B a).

The thing about TQM is that it has standard and systems to follow. But it's much more systematic than ISO which I find very static, document oriented. For TQM we have to be active because there are always ongoing issues involved in implementing TQM. My job is to make sure we keep up with this system, following the system and procedures, not interrupting it...(Mng B s).

Interestingly, despite approaching TQM in a less flexible manner and using the control approach as a way to align coordination from their subordinates, this management group was able to keep their staff motivated from the outcomes, of following systems and working procedures, as observed by one manager:

[What was your strategy to make your subordinate to be involved in TQM and HA?] They [senior management] told us what will be the outcome from doing it and so I told them [his subordinates] about the outcome...It was tough because we needed to do extra things, especially the document stuff which I

found a time demanding job, especially for technician people like us. We are not used to the paper work. I have to learn new things and attending a lot of training classes...But I have to make them do it, teach them, praised them, push them. It was hard but when we finally have a solid work, we started to see the outcomes which really rewarding...even more so when we achieved HA [Hospital Accreditation]. Now we have all the system up and run and everybody is happy with it [system] because they know when they follow though, they produce the outcome. Everyone is happy, management happy and our customers should also happy because we provide a quality standard service which should live up to their expectation...In fact, I am the happiest because it [the system] makes my job easier. Now I can monitor their work better and they [his subordinates] are more conscious when performing tasks. They know that when mistakes occur, they system tells where the mistake came from (Mng F b).

The last part of the above response was similar to one obtained from *Mng B c* in that TQM allowed them to have more power to control the performance of staff members. This point is made by scholars who take a critical perspective and saw TQM as one of means by which management make the work more visible and more controllable (Kelemen, 2000). The finding of this study supports the view that the management's construction of the "shared interest in customers" reality can be seen as a process of management's communication which serves their purposes of legitimisation via rationality and inspiring goals.

However, in the hospital studied, it seemed that "customers" were used by management in a subtle way to maintain coordination from the hospital staff members, specifically in regards to the hospital quality management program. This was because, while some comments such as "more pressure", "more responsibilities" and "more sacrifice" were obtained in the study, those who commented seemed to be willing to take on more responsibilities as a part of their commitment to provide a quality service to customers.

For instance, a few respondents had to work overtime to prepare documents especially when external auditors visited the hospital. One of them said she had no choice but to do it because "if we did not pass the reaccreditation, the customers will lose confidence in us..." and that, "it will have a great impact on the hospital's business which eventually affects me as an employee" (Opt F l). Another saw the sacrifice was far better than "taking away our quality crown" (Opt B p). Finally, one respondent

observed that maintaining quality is much more difficult and requires more hard work but it is something they need to do because:

Our customers come with an extremely high expectation now. They are willing to pay premium price but they also expect our hospital to deliver quality service and medical treatment that is worth their every Baht [dollar]. If we fail to do so, they would leave us. Nowadays private hospitals are very competitive and I heard that a few of them are trying to get accredited from JCIA (Mng F j).

These findings may lend support to scholars who take a critical perspective and saw TQM merely as a tool to empower management and that employees are being used by management as an object of exploitation (Kelemen, 2000; Zbaracki, 1998). However, as for the hospital studied, the articulation of the “shared interest in customers” was found to be a soft and sensitive approach to coordination, because it downplayed the staff members’ perception toward management’s use of authority. This practice is similar to the notion of “concertive control”, the management’s way to encourage subordinates to endorse and actively assist in the creation and enforcement of the condition of their own exploitation (Barker, 1993).

4.4.2. The Congruence of Customer Focus between TQM Reality and Non-TQM Realities

This section discusses the congruence of “customer focus” between TQM reality and non-TQM reality within the management’s interpretation context. The responses obtained indicated that the customer focus value already existed in some realities within the hospital prior to TQM implementation. Thus, management’s messages on customer focus regarding TQM were likely to serve more as a reinforcement and reassurance of the already existing customer focus value. This could also explain one of the reasons why responses which contained “resistant views” on TQM were rarely obtained in this study, apart from another possible reason that, during the time of study, the hospital had already made the change. Based on participant observation and the interview responses, respondents appeared to be motivated and enthusiastic when they interacted with or, talked about customers, particularly about two main aspects of (1) the hospital’s customer focus value and (2) the working environment.

4.4.2.1. The Hospital's Customer Focus Value

Respondents who worked at the operational level and had been working at the hospital for more than ten years suggested that “customer focus” was the value that the hospital had prior to TQM adoption. One of them saw a customer focus value was common to any hospital:

We are always sensitive to issues that related to customers, patients, and their relatives. It's not just the case of our hospital, I think every hospital shares a similar value...we exist to provide quality care and quality service to them...it's not that we became more caring about customers when we do TQM, no (Opt F t).

Whilst sharing a similar thought that customers were the focus of the studied hospital prior to TQM adoption, another respondent from the same working level observed that the customer focus value became more “tangible” after implementing TQM:

...actually putting customers first has been our [working] philosophy for a very long time but the quality program makes it clearer that this [customer philosophy] is our mission that we are committed to...the management people also emphasised more about this...I saw, after TQM, our customer focus value has become tangible. I mean, there are a lot of programs and activities that the management put into places that related to how can we provide better service to our customers (Opt F c).

One respondent who introduced himself as the hospital's “oldest employee” (ลูกหม้อ-*Luuk Mor*), provided a useful comment on the influence of TQM's customer focus had on the hospital's existing customer focus value:

We have been focusing on customer since day one. Our previous [before TQM] mission statement also addressed a similar thing like the one [the current vision and mission statement] we have now...um, how to put it...I think, in the past, when we called them [customers] patients, we tended to treat them like a patient. I mean we treated them well and we wanted them to recover from their sickness. But now, when we call patients, we treat them like customers, whom we not only want them to recover from their sickness but also want them to be happy and satisfied with our service. Yes, I think the difference between then and now is that, “then” we want to them to go home healthy but “now” we want them to go home healthy and happy with our service. And, if they are sick, their relatives or friends are sick, we want them to come to us or recommend us to their people (Opt F p).

Although it was observed during the study that hospital staff members often used the terms *customer* and *patient* interchangeably, this response revealed that the meaning of these terms had been extended by TQM. Influenced by TQM, the focus on customers or patients had been extended from their well-being to include their *happiness* towards the hospital's service, which was commonly referred by the

respondents as *customer satisfaction*. More importantly, in TQM reality, the focus of the hospital staff members was not only on patients or customers (who received services or treatment), but also on their company, families and friends.

In addition to this, it seems that part of the hospital's customer focus value was contributed to by the professional background of the healthcare staff members whose attitude and behaviour were already led by the customer focus value. In this study, several respondents whose experience of working at the hospital varied from more than 24 to three years and regardless of their working position spoke about their personal "customer focus" value as the reason for choosing to work in the hospital studied.

I am a compassionate person. I like to serve people and keep them happy...This is why I always want to work in a hospital because its business is about providing medical treatment and service (Mng B v).

In working, we need to understand who our customer is. When we have a clear mind, our job becomes easier...Having a good attitude and a compassion is important to work in a hospital than in a hotel because the client who come here is sick and their relatives are stressed and worried...my boss is really suited to work here. He has a service mind. The hospital's management had made a good choice in hiring him (Mng F s).

I love working with people, serving people, seeing people smile when I serve or helped them...I love what I'm doing and being able to earn a living from it (Opt F t).

This is why they hired me. I have experience in health care and I know what patients are looking for in our service, as well as what will turn them way (Mng F p).

Another important piece of evidence that supports the employees' positive attitude toward customers was related to the concept of *internal* and *external* customers which is often emphasised in TQM literature. However, the data obtained suggested that the shared interest in customers among the respondents was rather applied to those from outside the organisation, not from internal customers. Despite being able to identify their internal and external customers as well as recognising the need to provide service to both groups of customers, in practice, the internal customer was not treated as other than a work colleague who shared responsibility in serving external customers, which were identified as those who come to the hospital for medical and health care service and their families and friends, as well as those who come to the

hospital for work related purposes such as third party insurers, hospital visitors, and auditors from the hospital accreditation body.

Respondents seemed to be limited in their explanation of how they treated their internal customers, as compared to their external customers. This was generally true, except for a few respondents from the back office who seemed to willing to treat colleagues from other departments as their internal customers, but expected to be treated as, according to one respondent, “their internal customer, too” (Mng B n). By contrast, the enthusiasm of respondents towards external customers was noticeable from their responses on who were considered as external customers and how they were treated.

Although this study focuses on a non-medical treatment area, the difference of treatment provided to internal and external customers was apparent from the way the hospital approached their medical doctors who were considered both internal and external customers to the hospital. When asked a question of who were considered as his customers, one senior management staff member replied that:

Those who assign me jobs. They can be both internal and external customers. Internal customers are divided in terms of frontline and back office supporters. We see medical doctors as our external customers because they get very special treatment from us, even through technically they are internal customers. We value them and let them feel that we appreciate them as our external customers. Those hospitals with an international standard also treat the medical doctors as they external customers. We try not to interfere, but do our best to support them in every way (Mng B c).

One divisional director provided further details on how the hospital treated their external customers, doctors:

Doctors are being looked after as the external customer in a way that they don't have to buy their own food. We serve them. They don't have to come and pick up things, the nurse will do it for them. They don't have to park their car, they can use our valet parking service. However, when doctors serve the patients they are considered as internal customers. We need to work together to make sure we meet our standard of quality care. Also when complaints occur, we share responsibility (Mng B w).

As for a view from operational respondents, respondents from the back office and the front office seemed to share a common view on the importance of external customers, but with a slightly different use of metaphor when referring to external customers.

While respondents from the front office often used soft terms such as “valuable people”, “respected person” and “esteemed customer” (ผู้มีพระคุณ-*Phu Mee Pra Khun*), those from the back office often used powerful terms including “God”, “king” and “boss”. God, was mentioned by three respondents.

Customers are God. They come to use our service and they need to be served rightly and nicely. Patients, their relatives, doctors, people who come in to contact with us (Opt B p).

God. The extremely important person. I have both internal and external customers. But the external customers are VIPs for me, my boss and everyone who works in here (Opt B c).

One respondent from the front office observed at the beginning of the interview that he might provide a useful response on his approach towards internal customers, given he seemed to be highly motivated to provide his service to the hospital’s staff members. However, later in the interview, it turned out that the studied hospital was in fact his external customer. During the early stage of the interview, there was no clue that he was an employee of the hospital’s sub-contracted company, given his talks on daily activities similar to other management’s respondents such as morning brief meetings, training programs, and his talk on good relationships with other staff members of the hospitals. Observing his knowledge and enthusiasm towards TQM and hospital accreditation which he appeared to have more than some other managers, the researcher was prompted to ask about his motivation. His reply came as a surprise¹⁰:

[The hospital] is my customer...I think that I tend to be more enthusiastic than some other people [hospital’s employees] because I am a sub-contractor...I see myself as being hired by the hospital so I need to do my best to serve them. Also I need to do my best for my staff members’ sake. They [security staff] are poor and really need financial support for their families. I have to ensure they have a job (Mng F c).

It seemed that most of the respondents did not seriously take on the notion of internal customer, especially those from the frontline staff members. When asked about their opinion towards the concept of internal customer, they commented that:

¹⁰ Also a surprise to the researcher that he was not technically qualified to be a respondent but because the valuable information he provided the researcher decided to include him in the study.

To me I don't find the difference of internal customers and employees. It is difficult to have a similar treatment as an external customer. It is impossible and I don't feel bad about it. It's my job to treat customers, I mean external customers (Opt F t).

We have to choose...We cannot treat both internal and external customer at the same degree. With all the time and effort that we spend on external customers, we rarely have a chance to give ourselves royal service, you know. But I think we all understand this point...when the customer numbers got double, we got a double bonus too. So we can't complain about it (Opt F c).

Of course everyone wants to be treated like external customers, but who is going to serve us? It's not going to happen in reality (Opt F l).

These views from the operational level were similar to one senior official member who provided his comment when he was asked about his opinion on the notion which suggesting organisations should take good care of their internal customers according to the notion of happy employees make happy customers. He replied that:

I think people who say this is selfish. We are hired to serve customer so we are not suppose to think about ourselves too much. We need to serve customers by looking at what sort of expectations do customers have, so that we could align our staff attitude and behaviour with those expectations. We, especially the frontline people, need to adapt ourselves to comply with customer expectation. The back office will help the frontline by supporting them through various means...so that they are be able to provide services to customers...our hospital is focusing on customers. If we haven't done so, we wouldn't exist. If customers are happy, employees will be happy, too. We do support them financially when our aiming number of customers is reached...When we have a lot of happy customers, and when we reach our estimated [customer] numbers, we give a good reward to our staff members (Mng B c).

This comment, together with the impression of the previous responses seemed to suggest a different interpretation of the "value" stated in one of the hospital's guiding value, "we provide efficient healthcare to bring value to our internal and external customers". While this guiding value showed that both of the internal and external group of customers were acknowledged by the hospital, each group tended to receive a different value—that was *satisfaction* for the external customers and *financial benefit* for the internal customers. "Differences" between parties was discussed in previous literature as a threat to interpersonal relationships (Clark & Brennen, 1991; Hardin & Higgins, 1995). The fact that the senior management made a clear boundary of the difference in the "value" provided by the hospital was likely to be preserved in the relationships between internal and external customers.

4.4.2.2. The Working Environment

The shared interest in customers among the hospital staff members was likely to be strengthened by the environmental conditions they worked in. While both the management and operation group of respondents talked about their shared interest in customers in relation to the hospital's shared goal, which can be seen as the shared context at the organisation-wide level, it was found that the specific environmental context they were in, had influenced and reinforced their attitude and behaviour towards customers.

Three groups of the hospital staff members who were found to be influenced by a certain environment context included: (1) the hospital's management, (2) staff members of the TQM division and (3) frontline staff members. However, only the third group will be discussed here because the responses obtained suggested the socialisation with "customers" had an effect on their attitude and behaviour. As for the first and second group, the first group has already been the main focus of this chapter, whereas the second group will not be discussed here because their attitude and behaviour was found to be shaped by the work processes, similar to the findings to be discussed in the next chapter.

Although it was not unexpected that staff members who worked in the frontline showed their strong sense of shared interest in customers, this finding confirmed the finding of previous studies that social behaviour is formed and reinforced after a person has interacted with a certain situational context (Strauss, 1994). The fact that operational staff in the frontline had their daily interaction with patients or customers was likely to explain why their responses obtained often reflected their enthusiasm in serving customers and their compassionate attitude towards customers. Examples of these responses included:

I think the idea of continuous improving our performance and service is really good for us because it reminds us to be active and alert all the time...trying to figure out how to do things better for our customers each day. Before I was working in the call centre but hearing they say thanking on the phone was so different from seeing the person. Being able to help customers who were not well and they said thank you and smiled at you, it's a great feeling...the hospital provided Service Excellence training program was a good idea but it may be cheaper and better just to send them to work in the frontline. They will immediately get the idea, or they would give up soon after they [management] send them [staff from the back office] to work here [she laughed]...(Opt F c).

I have to keep both my eyes and my ears open for information and things happening in the hospital so that I could provide useful and correct information to them...some customers called in to make an appointment to see a doctor. If we could help them identify specialised doctors that could be best for their symptoms or their requirement for healthcare then it could reduce a chance for them to pay unnecessary doctor fee for seeing doctors that may not suit their health condition. It's a waste of their time and money...(Opt F t).

I am now better in handling customers, especially those who have problems and are unhappy with our service. Before I would leave it to my boss to handle them because I didn't know what to do. But I'm much better now. I'll try to solve problems by myself first...we learnt some tips from Service Excellence training program...not everything we learnt works though. It's very unpredictable and each day we have to serve many, many customers and they have different requirements as well as cultural background. So we usually learn new tactics, adjusting old tactics along the way (Opt F l).

Having more opportunities to interact with customers on a daily basis may explain why, as mentioned above, soft metaphors for customers such as “valuable people”, “respected person” and “esteemed customer” were used by front office respondents from the operational level. On the other hand, the fact that those from the back office had lesser opportunities to engage with customers on daily basis may affect their interpretation of customers by choosing a more powerful terms such as God, king and boss. While these terms imply the importance of customers, it also implied a sense of distance and superiority.

4.5. Discussion and Conclusion

This chapter provides the key findings on the pivotal role of the hospital's management in interpreting and constructing TQM reality. The data obtained found three specific roles of management in regard to their interpretation and construction of TQM reality: (1) introducing TQM as a business survival strategy, (2) communicating a shared common purpose, and (3) constructing the collective customer focus reality. The outcome of these management practices were found to contributed to a pattern of coordination that emerged from a “shared meaning and common purpose”. This pattern of coordination reflected the shared “end of desired state”, one of the key characteristic of coordination discussed in the existing literature (Chisholm, 1989).

However, the findings also provide some insight into the process through which “the end of desired state” is achieved—that is through the ability of management in

interpreting and constructing TQM reality that “fits” in, rather than competes with the hospital’s existing non-TQM realities. Because the TQM reality was constructed more as an extension of the current one, the hospital’s staff were able to associate and share their interpretation of the new, TQM reality and this increased their cooperation and participation in TQM related activities.

Within the hospital studied, the “fit” in management’s interpretation can be observed in the hospital environmental contexts: external and internal. The *external context* was related to the change in the external financial environment as a result of Thailand’s economic crisis in 1997. This was a major stimulus behind the management’s decision to adopt TQM as a means to improve the hospital’s internal quality. Dutton, Stumpf and Wagner (1990) saw that differences in contextual conditions create different motivating conditions for decision makers to construct their environments in particular ways. As for the hospital studied, management took a positive approach to their interpretation of the economic crisis and adopted TQM as a business survival strategy. This lends support to Westpal et al.’s (1999) proposition that organisations which adopt TQM during a time of uncertainty have a higher chance of successfully implementing the concept than in normal time.

According to Westpal et al., uncertainties encourage people to be willing to do things out of their comfort zone. As found in the study, the management’s strategic decision to focus on internal quality improvement, instead of business downsizing gave a sense of job security back to the staff members. This, in turn, allowed management to gain legitimacy as well as win support from the hospital’s staff members toward TQM adoption and implementation, despite the use of a top-down approach. Thus, the adoption of TQM during the economic crisis may be seen as a “ritual” or “ceremony” (Schein, 2004) that created a positive psychological effect on staff members and encouraged them to invest their energy in the management’s pursuit of the hospital’s quality improvement as well as its “ritual” outcome, external certification for its quality achievement.

As for the *internal context*, the management’s interpretation of TQM from its customer focus perspective was congruent with the hospital’s existing “customer focus” values. This “fit” interpretation had a positive impact on coordination, given

the responses obtained made in relations to customers were found to be associated with communicative attitudes and behaviours such as working together, message receptivity and more information exchange. More importantly, the term “customer satisfaction” was found to serve not only as the “end of desired state”, but also as “social motivation”, a characteristic that facilitates “social coordination” (Couch, 1984). This makes “customer satisfaction” both *a coordination mechanism* and *a legitimate social motivation* in its own right. This study sees that not all “end of desired state” demonstrated the same level of motivational effect and that some “end of desired states” may not have had a motivational effect at all. The fit in interpretation is seen to contribute to such effect.

Nevertheless, achieving such a fit may not be easy as it seems, especially for TQM which is seen as an ambiguous concept (Hackman & Wagemen, 1995; Kelemen, 2000). Gioia and Chittipeddi (1991) used the term “identity gap” or “cognitive distance” to describe ambiguity in the eyes of staff members as a result of the inconsistent interpretation between the organisation’s current identity and its ideal identity. Some ideas containing in TQM may not be applicable to some organisational contexts. The issue of internal and external customers is one good example. Although the hospital had succeeded in TQM implementation, the majority of staff members did not seem to take the idea of internal customers seriously, given the time constraints forcing them to place external customers as their priority. Implementing TQM thus depends on the management’s decision to tailor TQM strategy to suit a local context.

Although the data obtained may be not sufficient to uncover the actual process behind the management’s interpretation, two particular factors observed from the study were likely to have contributed to achieving a congruent interpretation. As the data obtained in this chapter is centred on the notion of customer focus, the following key factors are discussed within the context of “customer focus” interpretation.

First, a localised interpretation. Although the interpretation of TQM from its customer philosophy is seen to be appropriate and relevant to hospitals’ context (Shortell et al., 1995), this does not suggest that hospitals adopting TQM from a customer focus perspective will succeed in the implementation. Rather, TQM success is seen to depend upon a conceptualisation of what TQM’s customer focus means to each

particular contextual condition. For instance, a dedicated, service-oriented interpretation, such as keeping customer satisfied during their visit so that they would choose the hospital for their next visit, may be suitable for a private hospital like one studied and the staff members can see the value in the pursuit of this aspect of the interpretation of customer satisfaction.

However, this interpretation may not be suitable for public hospitals which already face an influx of patients. Therefore, a technical-oriented interpretation of customer satisfaction such as hygiene and patient safety may be more relevant to staff members of the public hospitals. In addition, even within the same organisational context, a further translation of “customer satisfaction” to particular working units is necessary, given the nature of working context and professional background. As found in the study, although the notion of customer satisfaction was often discussed among the hospital staff members from an external customer perspective, those staff from the front-line tended to be more empathetic when discussing about customers than those at the back office.

Second, the management’s ability to turn their interpretation into a shared reality. This requires several factors including management’s knowledge background and experiences, financial resources, and more importantly, ongoing communication at the organisational-wide level to allow management to obtain feedback and input toward the interpretation. This study found that the notion of TQM’s organisation-wide is “supportive” of the coordination outcome because it made managers aware of the need to ensure the hospital’s vision, goals mission was communicated at the hospital-wide level. The responses obtained from managers, especially those from the senior level, showed that both implicit and explicit customer-related messages were sent in various forms. This ongoing communication was found to be crucial in the construction of a shared reality. Not only did it show management’s long-term commitment to a customer oriented strategy, but it also reduced the possibility of misinterpretation which can occur due to the fact that staff members are active actors who constantly interpret and reconstruct their reality (Berger & Luckmann, 1966). When such interpretations are vague or contradictory, this can cause conflict and misunderstanding between staff members which could have a negative impact on coordination outcomes.

Chapter 5

Management's Construction of a TQM Influenced Working Environment

This chapter presents the role of management in constructing administrative structure and work processes which were influenced by TQM. The increase in the quality and quantity of communication flow was found to reduce the gap of knowledge between the management and employees. This, in turn, contributed to “shared understanding”, a second pattern of coordination that emerged from the study.

Although there were other administrative arrangements such as the hospital's integrated information, communication and technology (ICT) programme, budget allocations and human resources arrangements that affected communication and coordination outcomes, this chapter particularly focuses on four administrative arrangements that reveal the most significant characteristics contributing to the emergence of the coordination pattern of this chapter. These key arrangements are: (1) strategic business planning process, (2) training, (3) TQM division and standardised working processes and (4) meetings.

5.1.Strategic Business Planning Process

TQM experts stress the importance of a strategic planning process (e.g., Deming, 1986; Kanji & Asher, 1993; Oakland, 2004) because TQM is strategically linked to organisational goals (McAdam, Leitch, & Harrison, 1998). The evidence obtained suggested that the shared understanding of the hospital's shared goals, vision and

mission was facilitated through the process of strategic planning and the use of policy deployment. Through these processes, the strategic business direction from senior management allowed the hospital staff members, at their own level, to socially construct and co-construct the annual goals for their own division, department or unit. This strategic planning process was one of the most dynamic forms of coordination found in the hospital, given that TQM was adopted with a top-down approach.

The process of developing an annual strategic business plan begins during mid October to December each year. According to the planning process described in the hospital's document (Hospital's introduction to quality improvement activities, 2003), the hospital uses the information of the first three quarters together with the prediction of the last quarter of the same year to develop next year's plan. The process starts with data and information from various sources including *market research*, *competitor assessments*, *self assessment*, *doctor analysis*, *budget plan* and *competitive position opportunities*. While the first five sources were collected by senior management staff and expert analysts, the last source, *competitive position opportunities*, was obtained from a participative, bottom-up approach. Given that the process of gathering information on competitive position opportunities suggested a pattern of communication practices supportive of coordination outcome, the emphasis is on this emerging issue.

The competitive position opportunities were one of crucial elements for setting the direction of the hospital, according to one manager (Mng B t). To successfully outline the competitive opportunities for next year's plan, the hospital needs to, firstly, identify the set of "critical success factors" believed to strengthen the competitive position of the hospital. In order to obtain realistic critical success factors, the hospital's senior management asked each department to submit a set of critical success factors relevant to the expertise of their working area, as well as the hospital's shared goals.

Then, a brainstorming session was held at each working level, starting from the operational level where supervisors and operation staff get together to identify a set of critical success factors before submitting it to a departmental level, and then to a divisional level to refine a set of critical factors. The identified set of the critical

success factors from each division was then submitted to the senior management team who held a one-day meeting to finalise the hospital's critical success factors before using them to develop the hospital's strategic directions.

While most of the departments and work units tended to follow a similar process in identifying the critical success factors, a director of a support service division used a slightly different approach, which he called a "workshop":

At the end of the year, we need to identify problems and opportunities so that we could use them as our working direction for the coming year...We need to work in the same vision, the same direction and the same approach...I create what I call workshops. We need to let everybody understand our current positions and how we could overcome our weaknesses and highlight our strengths...We need to set a path and that path I don't choose alone. So I create a range of conversation with my managers to identify problems in their area...I mixed all the group of people from different departments so that they can have a view from other department outside my department so that they can help identify the problems...they need to work on their own to create our goals and objectives without the divisional director telling them what to do (Mng F e).

His approach was different from other divisions in that he encouraged a view from cross-working units within the same division to help other units to identify their strengths and weaknesses. By having different perspectives, each work unit was believed to achieve a more realistic analysis. This process is similar to Thompson's (1967) *reciprocal interdependence* where members within the group mutually engaged in discussion and contributed diverse views. Through learning problems and opportunities from other staff members, staff also realised their interdependent working relationships, in that the work of one working unit could back up or reinforce the work of another. One manager recalled her experience after learning from the workshop that her staff weakened the performance of another unit:

I was a bit upset with myself knowing that my people contributed to one of weaknesses of (other unit manager name's) working unit...It was so shameful to tell them that providing slow services was their weakness when, in fact, we were the trouble maker...We didn't centralise our working orders, my staff either sent individual or duplicated working orders. So the staff of that working unit needed to go back and forth to do the service that can be combined within one trip, or to find out that the job was done already...(Mng F j).

Once all data and information were submitted and the annual strategic business plan was put together, the management used a policy deployment approach to cascade the plan downward. Policy deployment, influenced by Japanese quality circles, is a

process for deploying and sharing the direction, goals and approaches of top management to make employees become committed to the quality goals of the organisation (Harrington, 1997; Kanji & Asher 1993). Although this suggests a top-down implementation, its implementation requires two-way communication between parties from different working levels or departments to ensure that their interpretation was consistent with the hospital's core strategy.

Based on respondents' explanations, policy deployment facilitated the company-wide planning process because every work unit within the hospital has to plan how it can contribute to the hospital's strategic direction. One department manager described how the hospital's strategic direction was deployed within her department:

For our department, we have our own annual plan, which we constantly re-evaluate and adjust...In order to develop our year plan, we firstly need to have 'directions' from the management for the coming year...to see what issues or areas they want to emphasize in the coming year. Then we hold a (departmental) meeting among our managers to decide the plan for our department that could support the hospital direction. Each manager will then bring our plan to their working unit to further discuss with their people so that they could set their own working unit plan. Once we have the departmental and working unit plan that everyone agree on, we submit to the management team and they will comment as well as allocate budgets for us (Mng B ml).

Her explanation suggested that the strength of the policy deployment was that it facilitated both vertical and horizontal communication. This contrasted to the hospital's former approach to its business plan which was developed by management and communicated downward to the working level. One manager provided a useful account using a journey as a metaphor to compare the formal approach and the policy deployment approach:

[The formal planing approach] Every department knew that they were going to Chiangmai [a northern province] but there were so many routes to reach Chiangmai. Some staff decided to come together while the others decided to go solo. They all arrived in Chiangmai, but at a different time... With the policy deployment, when we knew that we had to go to Chiangmai, we had a discussion within our team and set up our itinerary together. We made a decision together how to arrive with cost efficiency with reasonable time. We also assigned each staff a responsibility. For instance, one staff member booked the accommodation, another was responsible for the budget...Most importantly, and we made sure that we arrive Chiangmai together. It's more rewarding if we could celebrate our arrival together...(Mng B t).

This account illustrates the effect of the two planning approaches on communication practices and on coordination outcomes. With formal planning, although the hospital staff were well aware of the hospital's direction through one-way, top-down communication, there was still a gap between the communication message and the action required. This gap, however, was filled by the policy deployment approach which used both vertical and horizontal communication. While vertical communication sent an official message on the hospital's directions for the next year, horizontal communication encouraged the staff at different working levels to translate the hospital's direction into specific goals and objectives that each department specialised in and was responsible for.

Given that the hospital consists of many different working levels, and that each level also consists of different areas of expertises, policy deployment ensured that staff at each level shared the same understanding, and that the hospital direction was translated within the same context. While staff at the departmental and divisional level were able to carry out the policy deployment on their own, some working units at the operational level may require assistance from their manager. A manager of the security department needed to assist his staff when his department needed to translate 'Service Excellence', the hospital strategic direction of the year 2003, into an action plan:

They [his staff] got a bit of confusion. They consider security is their priority and now they need to also provide excellent service to the customers...They got confused because they thought serving the customers is the core job of the customer service department... So we discussed and shared ideas...I assured them that we still focus on our core job but we need to do some extra things to let our customers know that we care...In the end, we agreed that we have provide a friendly, security service...Greeting our foreign customers in English is also one of our plan. So our staff needed to learn a basic English conversation...(Mng F c).

While shared understanding and being able to perform within the same context seemed to be a positive effect of the policy deployment on coordination among staff at the operational level, a sense of commitment and ownership from developing the action plan seemed to play an important role in maintaining cooperation among staff at the management level (unit and department managers). One manager admitted that, "I feel it is an obligation to do whatever it takes to ensure my plan goes smoothly and successfully (Mng F j)." Another manager mentioned a similar thing:

...Our bosses are so supportive. They allocated resource and budget to support our proposed plan...sometimes, in the middle of the implementation, they ask if we need any support of any kind...I don't want to disappoint them (Mng B n).

There were at least five managers who mentioned that they obtained similar support from senior management. Interestingly, all of them seemed to know the strategy used to secure support from senior management. One said, "...as long as you propose a plan to improve your service or your working performance that will benefit our customers, you're sure to have a support from them" (Mng B w). Senior management's role in allocating budget and resources to support divisional and departmental action plans was seen as a method that was used to reinforce the hospital's message on its strategic directions. It sent an implicit message to the hospital's staff that actions reflecting the hospital's strategic directions will be rewarded.

The creation of shared understanding through the strategic business planning and policy deployment was an effective approach to allow the management and operational staff to see the same picture of the hospital direction as well as enabling certain sorts of action by creating a common meaning for individual and collective identity (Nohria & Eccles, 1992).

5.2. Training

Training is a planned programme of organisational change in accordance with the tenets of Total Quality Management (Anderson et al., 1994; Deming, 1986; Waldman, 1994), and is among the most popular techniques used for TQM implementation (Hackman & Wageman, 1995). In this study, training was a crucial mediator in the communication process between management and employees to reinforce shared understanding of new priorities required for the hospital to meet its shared goals.

Influenced by TQM's *continuous improvement* principle, training was addressed in the sixth guiding principle, which the hospital followed in order to achieve its vision and mission, "We encourage professional development and innovation through a constant process of learning" (The hospital's statement of guiding principles, 2003).

With this commitment, the education unit had been promoted to the Education and Training department with its main responsibility to “provide continuing education for all staff” and that “each instructor in the department is responsible to help develop the yearly training plan by the end of each year from the training needs survey and to set up classes according to the approved training plan” (Scope of Service 1.16).

Emphasising continuous learning, the hospital began to create a better strategic training direction which enhanced shared knowledge and an understanding of the hospital's quality improvement activities at the hospital-wide level. According to one divisional director who provided a comparison of the way the hospital approached training before and after TQM implementation:

We had training, workshops and orientation long before TQM...The effect that TQM had on these activities was that we had a better plan for them...Our staff competency plan is tied up with the hospital strategic plan. Each year, the training and education department will collect feedback on our hospital's needs as well as the employees' needs for training and submitted their training proposals to the senior management team who will review and decide the direction of our staff competency plan for the coming year...The good thing about this is that everyone will have to attend training that relates to our key direction each year. This allowed everyone to be informed and educated about the areas that need to have a shared understanding or shared interest...Before we focused on training for specific groups, which may cause some knowledge gaps between those who were trained and those who weren't...it is quite common that our staff will have to interact with different staff from different working units in providing service for the patients. So having training at the organisation-wide level is important for our hospital...(Mng B w).

In the hospital, there were two main types of training: (1) “mandatory training” which included new staff orientation (general orientation and clinical staff orientation), unit orientation, management training, and new key policy-related training (e.g., Patient Safety and Service Excellence) and, (2) “personal development training” which included internal training (e.g., 100 hours English classes and basic computer skills) and external training for programs that are useful and related to work practices, but not being provided inside the hospital (Scope of Service: Education).

However, the focus in this study is on “mandatory training”, specifically on TQM-related training courses, because of its significant role in aligning the new and existing staff members' knowledge, attitude and behaviour towards the hospital's shared goal. A range of TQM training courses were specifically designed to establish knowledge

of quality management processes as well as to instigate personal and organisational change through the enhancement of teamwork, cooperation and communication (Scope of Service: Education) at the group and hospital-wide level.

The courses provided at the group level mostly aimed at staff at the management level. Courses such as interpersonal skills, quality improvement processes and problem solving, team leading and building, statistics analysis, communication skills and effective meetings were seen as a way to empower directors, managers and supervisors with essential knowledge and skills in guiding their subordinates. Some of these courses aimed to improve people skills or soft skills, which were seen to underpin successful TQM implementation (Silvester, Anderson & Patterson, 1999).

As for the courses provided at the hospital-wide level, they were mostly related to behaviour modification and self-awareness such as Service Excellence and Patient Safety. These training programs were seen as a way to promote and reinforce collective attitudes and behaviours towards the hospital's shared goal. More importantly, it allowed hospital staff to understand other people's jobs and responsibilities and to relate themselves to others.

For instance, Service Excellence training was provided to every employee who works in the hospital, regardless of their position, and to all the sub-contracted employees who provide service inside the hospital. Evidence obtained suggested that training did have some impact on trainees' attitude and behaviour. The respondents who worked in the customer service department often reported that after receiving training, they found a positive outcome in the attitude and behaviour of the staff members who worked in other departments (either within the same division or outside their division), who had become more cooperative and helpful. Among them, one respondent said that she could differentiate between the staff who attended the training and those who had not:

Before, we had training related to providing services only among the front line staff such as customer service, receptionists, and public relations. But now everyone has to attend the Service Excellence, which is great...I can see the improvement of the attitude and manner of staff who attended the class...They are more aware about their manner...They are more aware that looking after the patient is not only the customer service's job, but it's everyone's job. When you see a patient on a wheel chair by themselves, you should go and offer

assistance. You don't need to call a porter; it's not about saying this-is-not-my-job...This improvement makes our job easier, especially in dealing or coordinating with other departments. Staff tend to see that we all serving the same customer. So they are more willing to do a task even if it's not their job...I can tell who had or hadn't attend the training...it's obvious from their attitude, the way they work with people, and the way they treat the customers (Opt F p).

Another respondent from the maintenance department also admitted that he used to think that dealing with customers was the job of the customer service department. But his attitude changed after attending the Service Excellence:

We learnt about new policies such as patient safety or service excellence from training...Maybe our job is not so related to customers when compared to those in customer service. But it's a good thing to know. Sometimes we also have opportunities to have contact with customers...like going in their room to fix up things...so we have to know how to approach them appropriately and nicely. We don't just go in and keep quiet. But we should ask some questions to show that we are concern about them...[such as] Is the air-conditioning too cold for you? Do you need to any help? Or, explain how to use some electric devices (Opt F p).

However, providing training at the hospital-wide level also had its challenges. Some regular annual training such as standard safety procedures or key quality-related policies were perceived by some respondents as repetitive. After attending some sessions on a random basis, the researcher also found that some of them were delivered in a unidirectional approach, where information flowed only from the instructors to the trainees (Observation fieldnote, September 9, 2004). Two respondents from the operational level commented that some sessions were boring, despite admitting that the training provided useful knowledge for them:

Most of the time we are happy to attend [training] as we learn new things. But sometimes they are a bit boring especially when they made it more like a lecture. So it needs a lot of attention, especially for some issues that are not relevant in my field...but sometimes, after the training, those irrelevant issues suddenly became so relevant in my work. I feel great and proud for things that I could remember from the training and being able to apply them in the real situation. Then I felt really bad for some issues that I failed to pick up from the training. It's like you've been giving a chance to see the answer and you missed out (Opt F k).

I love training especially when they present in the way I could understand and in a fun way. But sometimes they talked about the technical stuff or things that go not actually exist in my working units and so I have no idea how can I follow their ideas. So it becomes boring and I started to feel that it's a waste of time (Opt F p).

One respondent from the education and training division saw, besides difficulties involved in preparation for large scale training, two main problems of organisation-wide training, training overload and its short-term effect:

Some staff complained about having too much training. They said they needed to learn so many new things. They felt it [the training] was a burden especially when they already have so big a workload and so many things to learn about the new working processes required from the quality improvement...another downside of training is that it won't last. It only lasts about 3-4 months. We constantly need to re-educate them in order to maintain the kind of attitude and behaviour we want (Mng B j).

The fact that some employees found some training sessions boring or difficult could have a negative impact on the shared knowledge and understanding of the key messages intended to be provided in the training, and this could undermine the coordination outcomes. Although the data obtained was not sufficient to establish the main reason behind the problems of training, one possible reason from attending some training sessions and the new staff orientations was likely to come from the diversity of the employees' backgrounds.

If the training program is separated from what is understood by the receiver and what is being actually done on the job, that program could fail to deliver its message (Silvester et al., 1999). For instance, in the orientation for new staff, all the staff regardless of their working level and background had to attend. Given this, a staff member who was about to take a divisional director role or a housekeeper role had to listen to the same message, which they may not find to be relevant to their job or their existing knowledge, and this could take away their interest in the training.

Nevertheless, in this study, the arrangement of training at the department level was found to be a good solution to this problem. This was because department level training helped translate the hospital's key messages (e.g., missions, goals and new working policies) into appropriate contexts relevant to the staff members' background (e.g., working level and working unit) and allowed them to immediately apply the knowledge and skills in their day-to-day jobs. One respondent explained how the hospital's continuous quality improvement policies were passed from senior to middle management, who then developed key activities reflecting the policies and included

them into the department orientation program (considered by the hospital as part of the mandatory training) in a way that was useful to their staff:

When they initiated TQM, they started by providing us knowledge and ideas about TQM so that we could tell our subordinates. We had a workshop to look at our core jobs, identified problems, and designed activities to minimize the problem...Our quality improvement activity for year 2002-2003 was 'Touring program' [ทัวร์วัง โปรแกรม – an information session for new customer service staff members who will be shown around the hospital's premises and given a brief overview from staff members of each working unit on their services and facilities]. Our core service is to provide information, so it is important that our customer service staff members are well informed about the hospital and its service as well as knowing the same thing...the hospital's general orientation also has this kind of touring but it's more like a brief introduction of everything. The job of our customer service people required for in-depth knowledge...For example, our medical record is at the under ground floor of the car park. It is where all the patient data is stored and it is not the place the customer should go. If they need certificates, bring them to the 10th floor...We need to know about our food catering too. We need to know in details such as how many types of tray [e.g., size, material] we have, what are the food options...if our customers want to buy our uniform [the customer service staff dress in a Thai silk uniform] where can they get and pay for it...Our customer service's nature of work is quite difficult to have a definite scope on what sort of information they should know. We have our [department] own requirement that each staff need to learn and know about certain things in a certain period of time (Mng F j).

Given that the hospital studied consisted of various specialised working units and 17 working levels (Observation fieldnote, September 2, 2004), tailoring a training program that reflected the hospital-wide quality improvement policies and the specific task requirement of each particular department could enhance the coordination outcome through shared knowledge and understanding. One respondent recalled how training helped his department to have a better understanding of new concepts like quality improvement activities, and being able to engage in the hospital's quality endeavour:

Before we don't know much about ISO, TQM, JCIA and HA. We now are familiar with these terms because people talked about them quite a lot. All we know was that they are about quality improvement...one day the management people held a meeting in our security department and asked us to write our goals on the whiteboard. Some of us wrote that their goal was not to be yelled at. It made all of us laugh...then we got a lot of training and we slowly learnt more about the quality improvement...we now have the quality improvement goals for our department...We know that if we keep improving our performance and not making the same mistake over and over, we will not be yelled at (Mng F c).

Finally, another aspect of training contributing to coordination outcomes was reported from the respondents who felt themselves being equipped with knowledge and information from the training. Two respondents from the operational level shared a similar thought that the training allowed them to be more confident in interacting and communicating with other staff, as noted by one respondent:

...The training topics are related and helpful for our work. It supports our work a lot. We can now provide complete information or better respond to their inquiries because we know what they are talking about. Some people said we have too much training but we benefit a lot from it [training]. We can use it [knowledge obtained from training] in our daily work. Some issues that I used to ignore or didn't think that I would need to know became matters...it makes more sense to me after the training...I become more aware and I know how to response or react in an appropriate way (Opt F t).

The findings on training revealed its contribution on facilitating collective action. Some training sessions that were observed by the researcher may not appear to encourage trainees' participation; or being complained of by trainees as boring or not relevant to their jobs. Nevertheless, training served as a means to construct shared knowledge and understanding which allowed the hospital's staff, especially those who carried out the actual implementation at the operational level, to interpret and react in a manner congruent with the hospital's shared working values, when they encountered situations or problems in their daily operations.

5.3. TQM Division and Standardised Working Processes

At the hospital studied, TQM Division is seen to act as a "cross-functional liaison" role (Gittell, 2000) in coordinating and facilitating hospital-wide quality information. This section presents the role of the TQM Division in managing the hospital's document control and standardised working processes, which was also found to nurture coordination though shared understanding of formalised the hospital's standard practices.

5.3.1. The Establishment of the TQM Division

The TQM division was established concurrently with the administrative decision to adopt TQM in 1997 (The hospital quality journey: an introduction, 2001). One respondent pointed out that the success of TQM implementation arose from the authority and empowerment provided by the hospital administration:

...many hospitals did not do well in TQM because they did not have a well-established TQM division like us. They either set up a special team to be responsible for TQM activities or treat TQM more like project management. We are lucky that our management team provided all the resources...Quality improvement is the hospital's ultimate goal so the hospital issued several policies to support our [TQM] division and our activities...We have authorities and a system which allowed us to do our job efficiently (Mng B ml).

However, this study saw that the key factor behind the successful TQM implementation may have resulted from the fact that the TQM division was originally founded to function more as a communication coordination centre. According to the TQM division's scope of service document, the TQM division has its principal goal to, "coordinate with the administrative team and every department in the hospital for systematic and continuous improvement of the quality of treatment, care and service" (Scope of Service: TQM).

Within the same document, there were six key roles and responsibilities, and four of them were found to emphasise the need for the division to function as a coordinator and facilitator for communication and information related to quality improvement activities: (1) participate with the administrative team and working departments regarding TQM activities, (2) communicate about TQM to staff at all levels so that they are given knowledge and able to act accordingly, (3) collect, monitor, and use the results obtained from the quality improvement activities for continuous improvement with the administrative team and every department, and (4) ensure that every department implements the quality improvement program to the same standard and in an integrated manner (Scope of Service: TQM).

The emphasis on the need for the TQM division to perform the communication, coordination and facilitation role was found to particularly benefit the hospital studied. It allowed information and communication to move more effectively despite the hospital being a large and a highly structured organisation. More importantly, the fact that quality improvement was made a hospital-wide goal, and a policy in which every department had to be involved, meant that the TQM division had to perform its communication coordination and facilitation role at the hospital-wide wide level. Table 5.1 provides a brief summary of the main quality improvement activities of the TQM division. In performing these activities, communications were found to occur in various directions including top-down, horizontal and bottom-up.

Table 5.1: Roles and Responsibilities of the TQM Division

Roles	Responsibilities
<p>Manage the hospital-wide quality control process:</p> <ol style="list-style-type: none"> 1. the hospital-wide quality assurance system 2. the hospital-wide risk management system 	<p>Collect and analyse quality related data (e.g., incident reports, customer complaints, customer feedback and the hospital performance indicators)</p> <p>Monitor, review, and report quality related strategic data (e.g., inpatient and outpatient satisfaction survey, infection control and quality performance indicators)</p>
<p>Manage the hospital-wide continuous quality improvement (CQI) process</p>	<p>Ensure all departments participate and follow the hospital's CQI policies</p> <p>Monitor, evaluate and coordinate CQI activities of all departments (e.g., internal audits, quality activities, training and workshops)</p>
<p>Manage the hospital quality information collection</p>	<p>Document control system (filing, updating and documenting)</p>

(Source: Scope of Service: TQM)

5.3.2. Document Control and Standardised Working Processes

Among these quality improvement activities, the data obtained in this study suggested that the role of the TQM division in coordinating hospital-wide quality information collection through its document control and standardised working processes made the greatest contribution to coordination outcomes. According to one respondent, the hospital had a good foundation for its standardised working process from ISO9000, another quality management program which is known for its strong documentation processes:

We implemented ISO9000, before fully adopting TQM. ISO helped a lot in terms of setting up a good groundwork for our documentation system...However, TQM helps a lot with its continuous improvement concept. It keeps our system up and running (Mng B w).

As a part of the quality system, the hospital established a “document control system” to control distribution and maintenance of the hospital's documents and to ensure proper and accurate dissemination of hospital information (Scope of Service: TQM). All of the work-related documents, such as hospital administrative policies, standard operating policies, standard operating procedures, and work instructions were included in the hospital's document control system. This system was managed by the

“document centre”, a centre under the TQM division for maintaining the quality documentation system and ensuring that all the documents submitted from other departments conformed to the requirements of the quality system. For instance, there was a set of standard guidelines to instruct the hospital staff in preparing documents to conform with the hospital's documentation system. These guidelines included document styles (e.g., font types and font sizes), templates for both written documents (e.g., header, internal forms and lay outs) and visual documents (e.g., graphs and flowcharts), the approved standard abbreviations, as well as signs and symbols (Scope of Service: TQM).

Through reviewing, numbering and filing, updating and distributing documents, the document centre was seen to play an important role in facilitating the quality and quantity of information flow throughout the hospital. To provide convenient and timely hospital-wide access, all the work-related documents in the document control system were also stored electronically, “Online documents”. Given that the online documents served as the hospital's information resource centre, staff members were provided training on their use (Observation fieldnote, September 1, 2004). Being supported by the hospital documentation system, the respondents, particularly those from the operational staff, found the quality of information from the system allowed them to be more effective and self-reliant in performing their routines and also additional assigned tasks. This was because they could retrieve and learn about the most recent working policies and work procedures from the hospital's online documents.

The documentation system also assisted new or replacement staff to fit into the working system. One manager found that a common problem for new staff was not knowing the working process, and thus not being able to provide accurate or complete information. This was lessened because new staff could seek information from the hospital's online documents. Another respondent found the hospital's standardised working processes kept the work flowing despite the work process being disrupted by absent staff:

When we replace a new person, that person can continue the job without interruption or to delay our working process...all the working history had been documented so the new person can learn about the task and its progress...They

also can learn from our online document...so basically the new person could easily get on the job and carry on the task (Mng F b).

Besides this, the hospital's formalised and standardised working processes also improved the quality of information being fed into the system. This was because missing or erroneous information was minimised through following the instructions or requirements in the working procedures, as a respondent from the operational level reported:

[After TQM] Our communication is better because it's a quality improvement...The obvious thing is error is minimised and the work becomes more effective and efficient...we have lesser communication errors as we have a system for sending and filing documents. We have communication forms and processes so everyone is done the same thing (Opt F k).

The same person also pointed out another benefit in that knowing the steps involved in working procedures allowed her to prioritise her tasks and therefore she could produce a better result:

We are more clear with the channels of processing work...and by having a filing system means I can understand what they are up to and what kind of information they need because once they reach that stage they have to come back to me for the information as the process required them so...this way I could manage my time better... before it was hard to predict what kind of information they want and when they want it... so sometimes I have to rush preparing documents in which obviously the quality of my work may not 100% (Opt F k).

While the quality of communication flow resulting from the document control system was crucial for achieving coordination outcomes, it was the three emerging themes which reflected the characteristics of shared understanding: (1) dialogue, (2) interaction and (3) interdependence that nurtured the working characteristics of coordination. The first characteristic, "dialogue", a two-way, spontaneous communication, is seen as one of the most effective forms of communication practice that promotes coordination outcomes. Although dialogue was commonly found in responses related to communication activities such as meetings or brainstorming sessions (to be discussed later in this chapter), it was found that the formalised and standardised working processes provided a common set of concepts and enabled meaningful dialogue among hospital staff. This was because the formalised and standardised working processes created a language and a frame of reference

(Fairhurst, 1993) that allowed the hospital's staff to have a mutual understanding of the working processes.

Several responses reflected this theme. Most of them stressed including "sharing the same picture", "working in the same direction", "working on the same platform" and "talking the same language". One divisional director provided an account which showed that staff were able to engage in dialogue when they shared an understanding of particular knowledge provided in the standardised working processes:

Once we have these things [documents] in place, we could talk about HAP 4.07, which is our Incident Report, and they all knew what I meant and we could start discussing the following steps without explaining in details what involved in the next step, or who should take the responsibility...instead, we discussed unforeseen issues that might occur in the process (Mng B w).

Closely related to dialogue was "interaction". Although well-written forms and documents can be used as a means for communication within the working process, most responses suggested that other forms of communication including verbal communication played an important part in the working processes. One operational staff member observed that after implementing TQM, "Communication became more and more a requirement... you need to be more communicative... you cannot just follow the process" (Opt F l). This point was also stressed by one respondent from management:

[mentioned a variety of working procedures influenced by TQM] In order to complete these working processes, they [the hospital staff] need to communicate within their team or between teams all the time. They will need to write internal notes or progress notes to inform the need-to-know information to their work colleagues who will perform next in the line, given that not all cases are the same...most of the time, they need to come back to discuss and put together the paper work before submitting to TQM...so obviously, they talk more and see each other more, not just pass on documents along the [working] line (Mng B ml).

Finally, "interdependence" was also found to have an inter-relationship with the first two themes. The findings suggested that the hospital's formalised and standardised working processes sent a strong message to the hospital staff about co-dependent working relationships. The respondents, especially the operations staff, seemed to be aware of this. One of the good communication devices that exhibited the interdependent nature of work was flowcharts which are pictorial representations of the steps in a work process and commonly used as one of techniques for TQM

implementation to help quality teams in identifying opportunities to improve quality (Deming, 1993). However, in the following account, flowcharts helped locating their part of contribution within the whole process. A respondent from the operational level showed a working flowchart of his department and pointed one area midway to the middle of the chart and said, "I'm in charge of doing this process...Then the other lady in my unit will do the next" (Opt B p).

In addition to the work flow charts that illustrated the interrelated relations within a work process, the hospital staff experienced the need to cooperate and collaborate with others in order to complete their tasks on a daily basis. When they did not do so, they disrupted the system. One manager provided a good account on how the requirement of the standardised working procedures reinforced the need for working together:

TQM people chase after us...they will follow up our working process if we haven't submitted a report; because without our report, they cannot close the case...for instance, in case of reporting a customer's lost item, we need to put together how we investigated, the result, as well as possible solutions...but this will not satisfy the TQM department unless we submit a follow up report whether the item has been found or not, and more importantly, is the customer happy with the investigation, or with the result? If not, it's the beginning of another working process to regain the customer satisfaction, which, usually, people at the higher level will take on the case (Mng F c).

The hospital's formalised and standardised working processes were also found to have a positive effect on morale. Respondents reported that they felt valued because they could see how their contribution fitted into their work, and that without them the working processes could not be completed. In addition, by having standard procedures and instructions to follow, some of the respondents from the operational level reported that they had more confidence in their work, as well as feeling more pride that they could perform tasks that conformed to world class quality standards. TQM used a number of popular motivational devices including working design to enhance organisational members' work motivation (Lillrank, 2003) which allowed employees shared understanding of the means by which it is accomplished, and when they received regular, trustworthy knowledge about work outcomes (Hackman & Oldham, 1980). Several respondents, especially those from the operational level, stressed this type of motivation. Among them, one said:

I've been working here for 20 years. I had always been telling people proudly that I am working at [the hospital's name], and that, for me, used to be a very good reason for continuing working here. But with the process and system that the hospital set up during the past five years, it really makes me feel so cool...to be able to work within the world class standard system. I am not saying I am proud of myself but I just feel great doing things in a professional way (Opt F p).

The last key finding that related to the standardised working processes was the "incident report". The incident report was found to create a comprehensive form of communication practice and interaction that was supportive of coordination. This was because there were several activities involved in the incident report including a series of investigation and problem solving processes which required spontaneous, multi-directional communication directions. One manager in charge of the hospital's quality management provided an elaborate description of the processes involved in an incident report:

When we have an incident report, we need to discuss within our team to classify whether the incident arise from the medical treatment or the service section. If from the medical treatment, we need one day for conducting an internal investigation by talking to the staff involved. We usually begin with a discussion on the incident with a manager on the phone to elicit problems and evaluate whether the problem is needed an urgent response back to the customer who complained or we can follow through the customer complaint's feedback procedure...In case of a customer complaint for more than one thing, we have an "internal assign" form to assign a staff member who will be in-charge in contacting the customer as well as response to all the issues that the customer complained. Otherwise the customer will receive many phone calls from our staff members and each of them may explain different things or different stories...or in some cases, if we do not have the internal assign form, the staff may avoid their responsibility (Mng B ml).

The increase of this spontaneous, multi-directional communication, however, was found to be practiced mostly among staff members working at the management level (e.g., supervisor and unit or department managers). One manager commented that discussion with other staff within a team or between working teams was a common practice before the hospital adopted TQM. However, this manager found the standardised processes had a positive impact on problem-solving discussions, as the discussion was based on a common ground of shared understanding:

We have a guideline for discussions...We have standard procedures which allow us to have a purposive discussion. We have a timeframe for the investigation which people involved are conscious of; not much nagging jobs to do. Then we have all those forms and records which also help keeping things

on track until a particular incident report case closed. Everything is recorded and so people are more responsive for their parts (Mng B ml).

As for the operational staff, the incident report was found to have a positive impact on bottom-up communication. According to responses obtained from interviews, bottom-up communication had been a major communication weakness of the hospital and it was still the communication direction least used in the hospital during the time of the study. However, the majority of the respondents from both the management and operational level reported that they saw an improvement in bottom-up communication. Data obtained from the questionnaire survey also confirmed this improvement as the majority of the respondents were reported to be satisfied the most with information they sent regarding "reporting what I am doing in my job" (see Table 5.2, cell B1).

Table 5.2: Questionnaire Survey Results Section B: Satisfaction Index towards the Amount of Information You Sent

Information about...	Working Level			Working Section			TOTAL
	MNG	OPT	t-Value	Front	Back	t-Value	
B1: Reporting what I am doing in my job	21.16	19.62	1.8**	20.17	20.13	0.1	20.14
B2: Reporting problems in my work	18.67	16.41	2.6*	17.09	17.22	-0.1	17.18
B3: Expressing my opinions about my job	20.13	17.72	2.7*	18.7	18.46	0.3	18.54
B4: Asking for information essential for my work	18.46	16.93	1.6	17.94	17.21	0.8	17.45
B5: Giving my opinions about the performance of my immediate manager	19.03	17.22	1.9**	18.2	17.66	0.5	17.83
B6: Requesting clearer work instructions	20.01	18.32	1.8**	18.44	19.11	-0.7	18.89
B7: Reporting mistakes or failures that occur in my work area	19.89	17.67	2.2**	18.07	18.59	-0.5	18.42

* Significant at 0.05 level, **Significant at 0.1 level

Responses obtained from the interview with managerial staff also revealed their emphasis on the need to arrange feedback gathering mechanisms for collecting information flow from the bottom-line level:

Nowadays our bottom-up communication is getting better, although it's not yet perfect...We tried several ways to improve but they either worked for a short while or, not worked at all. What we have from TQM was the report system...we need our staff to give us their feedbacks or customers' feedback in order to make our quality system work...this feedback came through incident reports, customer complaints. They had several ways to let us know including emails or surveys (Mng B ml).

We are empowered with information. With all the quality records, statistic reports and our management review system, we are now managing by facts, by

what really happened at the operations...We can help them better...through supports like strategies, policies or resources...It allows the management to be in touched with the bottom-line people (Mng B c).

The respondents from the operational level also seemed to appreciate the opportunity to provide their valuable inputs. Two of them reported that:

They [the management] listen to us more because they want to know what problems make the customer unhappy. So they need frontline people like us, who provide services to the customers, to let them know...we feel our voices are more valuable and better heard (Opt F t).

We always report to our supervisor on things that have happened. We have a line of reporting [through a line of command], following the reporting procedure. As we are in the frontline, we know and see more things about customers' problems as well as their needs (Opt F c).

The improvement of information being fed upward through the hospital's feedback mechanisms (e.g., incident reports and questionnaire surveys) allowed the hospital to effectively manage its continuous quality improvement circle. However, this form of communication practice seemed to be the only distinct bottom-up communication practice found in the hospital. This implies that while the information related to quality improvement activities flowed better, those related to employees' personal concerns may not have. Although there were some channels such as a staff health and welfare committee and internal web-bulletin board were arranged by the management to encourage the hospital staff, especially those from the operational level, to share their thoughts and feeling on work-related problems or personal requirements, the data obtained from some operational staff suggested that these channels had not yet been effectively utilised.

Data obtained from the questionnaire survey also showed that the respondents were satisfied least with information they sent regarding "reporting problems in my work"¹² (see Table 5.2, cell B2). More importantly, the result also showed that the

¹² This statement item may share some similarities to the statement "reporting what I am doing in my job" which respondents rated the most satisfied type of information they sent upward. However, when the questionnaire was translated in Thai, the statement "reporting problems in my work" was translated to mean "reporting difficulties they encountered in performing the tasks". Based on two respondents whom the researcher came back to seek clarification of this contradictory result, they pointed out that this (translated) statement meant reporting problems in works that came either from their personal point of view or personal problems with other staff members and that they were, sometimes, uncomfortable to report these problems.

respondents from the management level rated their satisfaction higher than those from the operational level (statistically significant, $p < .05$). These findings suggested outside the quality circle, bottom-up communications remained one of the major communication problems for the hospital studied. Given the problem behind this issue was related to the findings in the next chapter, this issue will be explored further in Chapter Six.

5.4.Meetings

The requirement arising from continuous quality improvement activities was found to have a significant effect on the number of meetings as pointed out by the majority of the respondents, and the increasing use of a teamwork approach to meetings in the hospital studied. Table 5.3 provides examples of the meetings where quality improvement issues were reported to be discussed in the hospital studied.

Table 5.3: Example of the Types of Meetings Used in the Hospital Studied

Type of Meeting	Frequency	Attendant
FORMAL SCHEDULED MEETINGS		
1. Five levels of meetings		
1.1 Joint Executive Management	Monthly	Senior management team (Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Director and other associate officers)
1.2 Committees (e.g., quality assurance, risk management, staff health and welfare and bulletin board)	Monthly	Designated members from various working departments
1.3 Administrative Team (A-Team)	Weekly	One senior management official and all divisional directors
1.4 Department	Monthly	Division manager and all department managers
1.5 Unit	Monthly	Department manager, unit managers, supervisors and operational staff
2. Management Review on Quality Assurance		
2.1 Steering committee review	Quarterly	-Management representative (chairperson) -TQM department manager (secretary) -Representatives from other working divisions (e.g., medical affairs, education, nursing, outpatient, business department and support service)
2.2 Senior management review	Twice a year	Senior management and steering committee member
3. Annual strategic business plan		
3.1 Annual strategic business plan	Yearly	Senior management team and all divisional directors
4. Half-year strategic plan review		
4.1 Half-year strategic plan review	Twice a year	Senior management team and all divisional directors
INFORMAL MEETINGS		
1. Morning Brief		
1.1 Manager level	Daily	Divisional director, department managers Department managers, unit managers and operational staff members
1.2 Unit level	Daily	
2. Internal audit		
2.1 Internal audit	Varied as scheduled	Representative from TQM department, steering committee and designated auditors
3. Other small group discussions (e.g. incident report, customer complaints)		
3.1 Other small group discussions (e.g. incident report, customer complaints)	Varied	Working teams

(Source: Hospital Administrative Policy 4.2, 4.03, 4.09, 4.11)

In this study, meetings, when carried out in an open and participative manner were found to be the most effective form of administrative arrangements which allowed the hospital staff members to socially engage with a particular purpose and to negotiate and construct ideas and tasks, from which collective and organised action can follow. Evidence obtained suggested meetings served as a means to develop shared understanding of (1) the concept of teamwork, (2) the coordinated tasks and (3) problem solving and decision makings.

5.4.1. The Concept of Teamwork

Some management staff used their monthly department meetings, particularly during the first few years of implementing TQM, to transform collective ideas (the hospital's shared goal) into collective action. One manager said:

...sharing goals without acting together is useless...The whole organisation contributes to its success. It is impossible to succeed if everyone knows where we want to be, holds on that thought, but goes off in a different way in achieving our goals...I always emphasis this point to my staff in our department meetings (Mng F b).

Several respondents from the operational level who worked in a different departments from the manager quoted above also reported that their superiors always emphasised the necessity of teamwork during their meetings or group discussions. Some operational staff often used metaphors of “truck” and “train” as a reference of the whole hospital, and that they perceived themselves as one of its wheels. They further added, “...without us, the train cannot run” (Opt F p) or; “I’m a wheel, our CEO is a driver...They need us” (Opt B s). Interestingly, the latter respondent also gave another example of a fishbone, one of TQM’s tools for root cause analysis. According to him, “Our organisation is like a fishbone. The management people are the head, we are the bones”. He then drew a fishbone and pointed out one edge of the fishbone and said it was him. Although it was not clear whether this interpretation was from him or other staff members, it seemed that the concept of teamwork was embraced by him. His interpretation is similar to the concept of “equifinal meaning” of Weick (1979) which describes interpretations that are dissimilar but having similar behaviour implications.

Besides reinforcing the need to work together, another key message which management regularly communicated to their staff during meetings was the concept of team diversity which is imperative for implementing quality improvement circles (Deming, 1986). While team diversity was found to have a significant contribution to the collaborative form of problem solving (to be discussed below), in this section, the concept of team diversity was found to widen the staff members’ existing view of teamwork. One customer service officer reported that she used to think that teamwork was more about:

...sticking with my three other members, helping each other out. When one of us cannot work or are overloaded, we fill in their job. But now everyone in my

department is my team, the cleaner, the porter, the gardener, the security people...so we are trying to be helpful to them...but I admit that I might feel a bit strange doing the gardening! It has not yet happened though (Opt F t).

One divisional director also included representatives from the sub-contracted companies in his meetings because he counted everyone who provided service within the hospital a part of his team:

When the customers come in the hospital, they see everyone who serves them as the hospital staff, including our catering sub-contractor who serves a meal in a patient's room, or valet parking staff. So this is what I'm always trying to make our people understand. The contractors are part of us. So we all need to work with the same vision, in the same direction and the same approach. So we need to approach the contractors to make sure they understand this and that's why we need to integrate them in our system (Mng F e).

Besides increasing shared understanding through the flow of information, the inclusion of the sub-contractors as part of the team and in the meetings increased the synergy between the hospital and the sub-contractor companies:

[How have you been informed about the hospital policy?] Part of it comes from the meetings. They invited me to the meetings. So, I see their strategies and plans and I'll go back to look at my plan to see if it supports the hospital's strategy or not. If not, I need to change and adapt it to align with the hospital's. Before I had no idea about their plans so it was kind of guessing and hoping that what we did was good for them [the hospital]...I think, as we are a partnership, it is crucial to get along well with the hospital and its strategy...now are allowed to get involved more in the meetings, sharing ideas, and information...in these few years they have also supported us with the information that we need to know through forwarded emails (Mng F s).

Involving staff from various working units in the meetings also sensitized team members to the specific concerns of members from outside their own particular functional areas. One operational respondent reported that having an understanding of the nature of work of other team members who worked in another unit (within the same department) allowed them to work together better because:

...he knew what I do on a daily basis and so do I...before we were like, a bit tense...after we get to know him in the meeting, he told me that he thought I wander around too much, which I admitted that I did. But that's the way to spot customers who need help. He thought that my job had to always be with customers...now we get to know each other and we tended to understand each other more (Opt F l).

Although established shared understanding of the concept of teamwork in this manner did not reveal a form of physical interaction, it was found to nurture the "recognition

of mutual understanding” (Weick, 1979) among group members, thus allowing them to effectively engage in the other two forms of meeting which required physical coordinated action: (1) coordinated taskforces and (2) problem solving and decision making. These two forms of meetings were commonly practiced in the hospital. Based on the frequencies of reference obtained for face-to-face communication channels used by the interviewees, “meetings” received the highest frequency of 38, followed by “training and workshops” of 13 and “one-on-one discussion” of 12. Table 5.4, from which the two forms of meeting to be discussed in the following sections were based, presents the types of meetings used by each group of the respondents, along with the main purpose.

Table 5.4: Frequencies of Meeting

Type of meeting	Purposes	Management		Operation		Total
		Back	Front	Back	Front	
<i>FORMAL</i>						
- Monthly meeting Management, department, unit	Shared and passed on information upward and downward (through the line of command)	3	2	2	2	9
-A team	Discussed problem being sent from the operational level; provided feedbacks to operational level	3	1	1	-	5
-Multi-disciplinary (committees)	Discussed quality related issues; collected feedbacks; followed up and monitored work performance	6	1	2	-	9
-Project, ad hoc		1	-	1	-	2
<i>Total</i>		<i>13</i>	<i>4</i>	<i>6</i>	<i>2</i>	<i>25</i>
<i>INFORMAL</i>						
-Morning Brief (daily)	Discussed problems, solutions, and ideas; coordinated tasks between units; shared information and knowledge; followed up and monitored tasks; on-the-job-training	1	7	1	1	10
-Small team meeting (weekly, bi-weekly)	Discussed problems; followed up tasks; monitored outcomes	2	-	-	1	3
<i>Total</i>		<i>3</i>	<i>7</i>	<i>1</i>	<i>2</i>	<i>13</i>
TOTAL		16	11	7	4	38

(Source: based on responses obtained from in-depth interviews)

5.4.2. Coordinated Taskforces

In this section, two forms of meetings were found to contribute the most to strengthen the use of meetings as a means to coordinate taskforces: (1) the monthly meeting and (2) the morning brief.

5.4.2.1. The Monthly Meeting

The continuity of information flow facilitated by the scheduled arrangement of meetings was found to be supportive of the shared understanding of coordinated tasks. A formal process of moving information throughout the hospital was the five official levels of meetings organised on a hierarchical basis: *joint executive management*, *administrative team (A-Team)*, *department*, *unit* and *committees*. One executive official referred to these five levels of meetings as the hospital's "communications circle" (Mng B c). Meetings at each level were held once a month, except for the A-Team meeting, where one senior management officer and all divisional directors met on a weekly basis to provide timely feedbacks or decisions (Mng B c). The scheduled meetings allowed communication to flow horizontally within each level of meeting as well as downward and upward between each level of meeting; according to one manager:

I see more of horizontal communication; especially within my department...we also have monthly meetings. After the meeting, we report our meeting results to my boss during our own meeting [divisional meeting]. My boss then brings the result of issue we discussed to her meeting level [A-team] back to us. I think the information spreads much quicker this way (Mng B a).

The flow of upward and downward communication through various levels of meetings was critical for the hospital's continuous quality improvement activities, as noted by the same executive:

In our communication circle, communication occurs in every direction...it has to be fast and efficient. When we have new policies, we need to communicate downward in a way that everyone will have accurate and rapid information. And, we also rely a lot on communication upward, so that we could provide strategies, solutions or formulate a policy for them to implement in a timely manner. So it's a circle of communication...if one of our communication levels is not efficient, it would affect the whole circle (Mng B c).

Nevertheless, these hierarchical levels of meetings seemed to be used and perceived differently between respondents from the management and operational level. Besides the fact that management respondents seemed to engage in meetings more than operational respondents (based on Table 5.4), the meetings at the management level (joint executive management meeting and A-Team meeting), were often used as an open forum for brainstorming and discussion of issues, particularly those received from the operational level, and as an effective top-down communication channel. A

response similar to the comment below was commonly heard from the management respondents:

We see it [the meetings] as our main communication channel where management teams can communicate downward to working units, apart from the fact that we have a clear line of command within the working units (Mng B w).

The operational respondents, however, seemed to perceive that their department meeting was functioning more as a top-down communication channel and less for a bottom-up communication. For instance, one respondent found that:

...there are meetings among managers. They discuss issues such as incident reports, statistical records and the issues from the operational level and they will give directions, solutions or new working procedures to us. I think the meeting has been set up this way...as a platform for this kind of communication (Opt F p).

Another operational respondent provided a similar view:

...Our department meeting provides us with a summary of what has been happening, what are the problems as well as all must-know information such as new working policies or solutions (Opt F c).

Although the department meeting was often perceived and used as a vertical communication channel, especially for top-down communication, both the management and operational respondents seemed to be satisfied with the amount of information they received through meetings. According to the result from the questionnaire survey, "department meeting" was rated the third most satisfaction communication channel, among the 12 communication channels they received information from (see Table 5.5: Questionnaire Survey Results Section E).

Table 5.5: Questionnaire Survey Results Section E: Satisfaction Index You Have towards the Amount of Information You Are Receiving Through These Channels

From...	Working Level			Working Section			TOTAL
	MNG	OPT	t-Value	Front	Back	t-Value	
E1: Face-to-face contact between myself and my managers	19.79	18.34	2.0*	18.74	18.87	-0.2	18.83
E2: Face-to-face contact among people in my work area	23.05	22.63	0.4	21.53	23.36	-1.9**	22.78
E3: Telephone calls from my managers	19.85	17.44	2.5*	17.35	18.68	-1.4	18.26
E4: Written communications from my managers (memo, letters, etc)	18.79	18.21	0.6	17.66	18.76	-1.1	18.41
E5: Policy statements	21.29	21.51	-0.2	21.27	21.51	-0.2	21.43
E6: Notice boards	18.48	17.18	1.3	17.83	17.52	0.3	17.62
E7: Internal publications (magazines, newsletter, ect.)	16.38	17.31	-0.9	18.14	16.46	1.6	17.00
E8: Internal audio-visual (videos, films, slides, ect.)	14.63	15.61	-1.0	14.91	15.45	-0.5	15.28
E9: Intranet, emails, webboards	18.57	18.43	0.1	17.78	18.8	-0.8	18.47
E10: Small team meetings	18.18	18.60	-0.4	18.98	18.22	0.7	18.46
E11: Departmental meetings	21.34	20.96	0.3	21.63	20.84	0.7	21.09
E12: The grapevine (by random word of mouth)	10.53	12.60	-2.3*	11.60	12.04	-0.5	11.90

* Significant at 0.05 level, **Significant at 0.1 level

This could suggest that the use of the monthly department meeting as a process of moving information between hierarchical levels of meetings played an important role in facilitating a shared understanding of essential working information procedures (e.g., new policies and amended working practices) and important administrative messages at a hospital-wide level.

This conclusion is supported by the use of meeting memorandums and minutes of meetings. Recording meetings in written form was one of the Hospital Administrative Policies (HAP) that applied to each of the five levels of meetings. The hospital's communication policy stated that, "In each meeting there will be an identified agenda, and recorded minutes of meetings to allow for continuous follow-up of the relevant issues" (HAP 4.11 communication). However, based on interview responses, the use of the minutes of meetings was found to be relevant to the committee meetings and the formal meetings, whereas the use of the meeting memorandums was relevant to the department meetings. After each department meeting, a meeting memorandum would be circulated among the staff members who were asked to record their signature after reading the memorandum. A copy of meeting memorandums was also posted in a common area in each working unit.

The customer service department had an interactive approach to the use of meeting memorandums. Given their busy working environment, some staff may not be able to attend the meetings or to stay throughout the meeting as they need to provide service to customers. The department manager used a new approach to circulate meeting memorandums:

What we do is to have them read a meeting memorandum in front of their supervisor, who have to ask their subordinate if they have any questions, or need some clarification. If there is an unclear point, the supervisor needs to explain it clearly. If it is still unclear, we will have a small meeting with both the supervisor and the subordinates. Once they are clear, they have to sign their name on the memorandums (Mng F j).

The minutes of meetings were recorded in a standardised format and stored according to the hospital's document filing system with a minimum of one year retention (HAP 4.11 communication). Besides providing a summary of issues discussed or decided in the previous meeting, the minutes of meeting was found to allow meetings to be organised and structured. Based on the analysis of the year 2003 record of minutes of meetings of the hospital's Bulletin Board Committee, the minutes of each meeting followed the same agenda which consisted of four key issues: (1) approval of minutes of the last meeting, (2) follow up issues or tasks being discussed or decided in the last meeting, (3) new information, news (from various working sections such as doctor news, TQM news, social news, and administrative news), and (4) extra issues, ideas, or recommendation for activities related to the bulletin board (Bulletin board committee's minutes of meetings, year 2003).

The hospital's minutes of meeting used a table as its standard format. The table was made up of four sections: Agenda, Minutes, Follow up and Responsible Person. It was found that the minutes of meeting played an important role for the use of meeting as a routine coordination (Gittell, 2000). Besides allowing everyone in the committee to have a clear understanding of the tasks and responsibilities assigned for certain committee members, the pressure of having their tasks followed up in the next meeting made some committee members ensure that they had made some progress to report in the meeting. According to one manager,

...it's OK to report "no progress" for my assigned task in the next meeting and being recorded "no progress" in the minutes. But it wouldn't be nice if I have a another "no progress" record in a minutes of meeting of the next meeting...it

became a bad record for me...I think other members should feel the same way...we sometimes meet before the meeting to put together our tasks or ideas so we have some progress to report in the meeting and that and to be recorded in the minutes! You know, everyone can ask to read our minutes, not just among our committee members. It is also possible that the external quality auditor will review the minutes...so it matters to have a good record to impress them (Mng B s).

5.4.2.2. The Morning Brief

Unlike the monthly meeting, coordinated taskforces from the morning briefs was often found in a form of pre-specifying the tasks to be performed between various working units within the same working division or between working divisions. However, the morning brief was heavily used in the front office working section, the support service division. At least four management respondents from the front office provided similar responses that the morning brief was used to “discuss and assign tasks among working units” (Mng F c), “coordinate task forces and discuss the sequence in coordinating the tasks” (Mng F b), and “schedule our work and spread out responsibilities for the different pieces” (Mng F s).

One manager described how the morning brief functioned:

We have morning brief every morning from 8.30-9.00 am. Our support service consists of nine departments and units...it is often that one department would need assistance from other departments or units. For example, if the VIP customer service department informs us that there will be one very important person come in tomorrow, we need to decide what are the special arrangements need for that VIP person...In this case, the VIP customer service department would need to work closely other units such as the security, housekeeping and catering...so it's more like a task briefing for people involved in providing service to our customers...tasks and responsibilities are assigned within our ...After the morning brief, I will have my own morning brief with a group of supervisors who work under me...they [supervisors] then either have a one-on-one brief or a small group discussion within their team...Then there are on-going communication between me and my team during the day. If we have problems from the task assigned or things did not turn the way we had agreed on, I will bring the issues back to discuss in the morning brief [among managers] on the following day (Mng F j).

Another unit manager also used a similar pattern in the use of the morning brief, except for the fact that he held the morning brief at his department level before attending the morning brief at the divisional level because he wanted to:

Collect feedback, problems, as well as follow up the working progress before taking the feedback and information back to the morning brief at my [divisional] level (Mng F c).

In the morning brief, information was found to flow from various sources and directions. The discussion in the morning brief was often based on top-down information that the divisional director received from the meeting at his level (A-team); from one-on-one discussions between the divisional directors with the top management; and from the bottom-up information that the department or unit managers received from the operational staff who worked under them. Therefore, the intensity of information flow within the morning brief had not only facilitated coordinated taskforces, but it had also encouraged a form of proactive approach to coordination. One response reflects well on this proactive practice:

[In the morning brief] He [the divisional director] briefed us [department and units managers] about what he has been informed or learnt from the A-team meeting, so we got updated information on everything, not just issues related to our support service...We learnt that our hospital has high admission rates and all our rooms are always booked out. So we discussed how we could support them [medical treatment areas]...planning ahead so that we could provide immediate service is really how the Support Service division should perform... In the discussion, we learnt from the maintenance department that we have about 5-10 spare beds in case of emergency. So we came up with the spare bed plan...to put together this plan, it needs a team effort...it isn't just about how many spare beds do we have...For instance, the technician need to ensure that the bed is ready to use, the housekeepers need to prepare extra linens, and we need to inform other units outside our division about the spare bed plan and how they can place a request form...Then, our supporting service people need to keep their eyes on the customer volume...the housekeeper can also help us in observing the trend...So when it reaches the maximum level, we could respond immediately...But, most importantly, our customer service people must know about the spare bed plan. So that when the customers complaint about a long wait for a room, they could inform them about the plan and keep them update when will they get a room...if we do not have the plan or if we have, but our people don't know about the plan, the best they could do would be taking complaints from customers and apologize them. But this is not enough if we want our customers to be satisfied with our service (Mng F j).

Although coordination of taskforces facilitated by the morning brief may improve the quality of customer service, the morning brief was not introduced immediately after TQM adoption. Rather, it was introduced by the divisional director who was recruited from the hotel industry because the hospital, "...wanted to improve our service quality by incorporating a hotel touch to add strength to our signature service (Mng B c)," as explained by one senior manager. The arrival of the divisional director had resulted in

several changes that had a positive impact on coordination outcomes. The changes that facilitated communication flow included combining different working departments and units (e.g., customer services, VIP customer service, call centre, security, transportation and maintenance) to form the support service division, reallocating tasks and responsibilities, flattening the line of command and, most importantly, introducing the use of the morning brief. This finding suggested the influential role of a leader in reconstructing the divisional structure that enhanced opportunities for staff member to socially interact within the division.

On the other hand, this divisional director can be seen as a part of the top management arrangement in recruiting the right person perceived to have the right fit with the hospital's shared goal and working values. As a result, this director was able to reconstruct the divisional structure and system to be supportive of the hospital's shared goals as well as the nature of support service division, given his expertise in the hotel industry. One department manager within this division provided a good comparison before and after the use of one of his initiatives, morning brief:

Before, information was distributed within the line of command. The cleaners and technicians were not seen as workers related to customer service. Also our customer service department was under the business development department. There was no communication gap between us...we were informed well...but mostly through internal memos...I was happy with my previous boss though, she was kind and helpful...but somehow I felt a bit of a distance. Maybe because she also had to do those marketing things as well as looking after our department...our office is also located in a different building. So once we have our own boss and that he is always with us in the frontline. Also we felt a sense of togetherness once we [all different departments and units] were placed under the same division...we get to know each other more from the morning brief, it really brought us together...the first few morning briefs made us realised that we all work for the same customer. Therefore, we really need to work together, put our heads together...(Mng F j).

The benefit of the use of morning brief had also been appreciated by the operational staff who felt the internal communication within the department was:

...much, much better than in the past. Things get done very quickly, easy and smooth. If our boss orders or says something, all people in the department knows the same thing, and at almost the same time. So we are working along the same direction (Opt F t).

Besides sharing similar ideas to the previous respondent, another operational staff member found the morning brief educational and fun:

Our boss used the morning brief as a way to share knowledge with us. We love it. Me and my colleagues are happy to attend the morning brief because we always learn new things...[But meeting every day is taking a lot of time?] Not really, if we are busy we don't have to attend, it's not compulsory but we like to attend, it's fun; it is a good way to start the day. Plus we always learn new things. [Has there been any improvement in terms of communication?] Yes, it's better both inside and outside our department. We have less communication errors and we have less complains from both the customers and people who work outside our division (Opt F k).

Finally, learning from management practice, staff members at the operational level brought the concept of morning brief into their level in order to coordinate the sequence of tasks within their team each morning. One respondent from the operational level shared his practice:

We need to talk within our team to organise our tasks. For example, if we have to do a job in the same patient's room, we need to coordinate who is going to do what first, second and third...a job like painting may need to be done before the installation of the air conditioning. When the electrician has finished his job, a person who did the painting job may need to go back to the room to do the touching up. Finally, the cleaner can come in to clean up the room. If we did not coordinate the tasks, we would waste our time and resources (Opt F p).

5.4.3. Problem Solving and Decision Makings

This final form of meeting suggested the most comprehensive form of mutual interdependence as staff members were able to make a "mutual adjustment" (Thompson, 1967) in their discussions. The use of cross-functional teams to identify and solve quality problems is a common practice of TQM (Hackman & Wageman, 1995) in order to bring different ideas and perspectives, as well as expertise in identifying problems and solutions (Oakland, 2004). One respondent from the management level credited TQM for encouraging the use of meetings at a different level as a forum for discussing problems:

The good thing about TQM that is important is that we have an administrative meeting every Wednesday for about three hours allocated to discussing problems. Then once a month we have another three hours to discuss problems with the entire management team. Then we also have a day-to-day discussion with our team of doctors and nurses [who are involved in providing non-medical services for international patients] every morning. So the meeting is probably the most important and useful way to get things done around the place and this is from TQM (Mng F p).

The way the meetings were arranged at a different level was found to provide a forum for staff at the management level to discuss problems and brainstorm solutions

between staff from different working teams so that they could have a diverse understanding of possible causes and solutions to organisational problems. This is important because obtaining the best possible solution was emphasised by senior management, which includes the chief executive officer, chief operating officer, chief finance officer, and chief medical official (HAP 4.02 Management review). Two responses obtained from the divisional directors reflected on this:

We can go knock on doors and talk to our senior management people anytime, but always making sure that we show up with solutions (Mng B k).

...when you come to see our senior management, you need to come with solutions, not with problems. The management believe that you are the group head so you should know best about the problem and more importantly, solutions to that problem...(Mng B w).

Although various types of meetings used in the hospital studied were found to be associated with problem-solution discussion, the data obtained in this study revealed two factors, influenced by TQM, underpinning the use of meetings as a source of collaborative problem solving: (1) the hospital's continuous quality improvement policy and (2) the continuous improvement of service quality. These two factors are presented below.

5.4.3.1. The Hospital's Continuous Improvement Policy

The hospital's continuous quality improvement policy has promoted the establishment of cross-functional or multidisciplinary team-based meetings. According to the hospital administrative policy on Continuous Quality Improvement (CQI) program, all departments have to set their own CQI team and that "all staff are responsible for participating in unit/cross-unit department/division (multidisciplinary) teams to achieve effective continuous quality improvement" (HAP 4.03 continuous quality improvement). CQI is "The patient-centred process to identify, assess, implement, take corrective action and continuously improve its quality to achieve positive patient outcomes" (HAP 4.03 continuous quality improvement).

Problems occurring within the department were reported to the department quality team consisting of representatives from different working units and different levels to discuss and brainstorm, using a root-cause problem analysis tool called FADE.

Hackman and Wageman (1995) saw TQM's "cause-effect" tool as a form of "process-management heuristic". In the hospital, FADE is an acronym for:

Table 5.6: The Hospital's Root-Cause Problem Analysis (FADE)

<ol style="list-style-type: none"> 1. Focus: identify important activities for improving performance 2. Analyse: establish standards, determine, identify indicators to measure standards, data collecting and analysis for improving performance 3. Develop: monitor, evaluate and get opportunities to improve continuously 4. Execute: evaluate the effect and outcome, if the target goal is not met, re-evaluate and identify root cause of the problem to improve performance continuously
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(Source: HAP 4.03 continuous quality improvement)

The result of the meeting was brought by the department manager to the CQI weekly meeting with the TQM department to update the report of CQI activities. If problems were complicated, "We will bring the Quality Assurance (QA) committee to the joint executive management meeting" (Mng B ml). The use of FADE among multidisciplinary team members within the department, between departments and across working levels encouraged clarity in problem solving discussions as well as enhanced integrative problem solving ability, according to one of the responses obtained:

... I think we benefit a lot from this multidisciplinary team approach. People from various units brought with them their own expertise to our meeting. So we tended to have diverse views on specific problems because each member has some expertise or specialities to share and educate one another...Sometimes I heard a very insightful point which never came across my mind...the use of our root-cause analysis tool also helps putting things in perspective as well as refining our thoughts towards a sound solution...(Mng B w).

5.4.3.2. The Continuous Improvement of Service Quality

The influence of continuous improvement of service quality on collaborative problem solving was often associated with the use of the morning brief among the "front office" management staff to solve problems in daily operations. The consensus from the responses obtained from the management respondents suggested that the inclusion of meeting members from across a range of functions in the morning brief had allowed them to solve the overlapping problems that occurred between their working units and departments effectively and in a timely manner. This was because the use of

the morning brief allowed team members to take advantage of the diverse understanding of possible causes and solutions, and that each staff member had the authority to make a decision in the meeting. Among the responses obtained, one department manager provided a useful comment and example:

The good thing about the morning brief is that we have all the head of each department here [the support service division] who can make a decision or approval on things we discuss, so we get immediate feedback and solutions in one meeting...For instance, we have a complimentary transportation service for customers everyday from 7am-7pm. However, our customer service staff had complaints from customers that they cannot use the service after 6.30 pm. So I brought this case to the morning brief and the transportation manager explained that they still provide service until 7 pm. However, sometimes the last car was in service and came back nearly 7 pm. So they cannot serve the customer who put order 10 minutes before 7pm. Once we learnt about this, we set a rule together that our staff will not place a booking for the service after 6.30 pm. This new rule is shared among managers in the meeting who will go back to inform their staff. This is because the "complimentary car request" is not only made by my department [customer service] but also by the international patient centre as well as the translator unit. We have to ensure that everyone in our division knows the same thing and that the problem will not happen again because it affects our quality service...(Mng F j).

The respondent from the operational level seemed to understand the purpose of the morning brief and how it functioned. More importantly, the rapid feedback and solutions that they received from the morning brief not only encouraged them to immediately report problems, but also increased their satisfaction. The following provides accounts received from two respondents from the operational level:

With the morning brief, all the managers within our division get together and try to solve the problem and find possible solutions that suit the situation. Some problems overlapped between two units, so they need to consult each other in order to solve them. Also we have people who are able to make a decision in the morning brief. So the solutions have been agreed and supported by all the managers. I'm very happy with morning brief. It's great, especially it allows us who work at the frontline to communicate problems we face upward and to have quick feedback and a solution back. Before when we reported upward we have to keep waiting and waiting and, as a staff member who faced the problem, I felt frustrated. It was not easy to do your job when you had no solution and you could not make your own decision because it's beyond my authority (Opt F t).

If the customer complaint is about not having a parking spot, we will call the manager in charge to solve the problem on the spot. And, we also tell our manager to bring this issue to discuss at the morning brief, so that our boss and other managers could help finding the solution and setting up procedures so that when the problem occurs again we would know how to deal with it. In this way the problem is being dealt right away and the solution is provided... Our boss is now better informed about the problem. Before they are not well

informed and could not quite understand why this problem occurred, or how it occurred. So the solution cannot be found. What they did best [in the past] was to comfort us that it's normal for customer to complain, just be patient. They [managers] understand that complaints could happen but that was not what we want. Besides their understanding, we also want their solutions to the problem (Opt F p).

Nevertheless, there were some negative findings on the use of meetings. Most of these were obtained from management respondents and often related to informal meetings such as brainstorming for *ad hoc* projects, or special activities. Negative comments on meetings such as “no conclusion” and “waste of time” were made by the management respondents, while one response obtained from the operational level was related to not being informed about the meeting results. Below are accounts made by one respondent each from the management and operational level, respectively:

I don't mind having too many meetings. Most of the time, they are well-structured. [provided examples]...like having the meeting agenda sent to us in advance, having a time limit for each topic discussion or being told what we want to achieve in each particular meeting...Usually those useless meetings are unscheduled meetings such as meetings for special events or brainstorming for pilot projects (Mng B t).

Before I didn't know that we haven't been well informed until I had a chance to attend a meeting on behalf of my boss in which I learnt that there were so many information that was passed on in the meeting...after attending that meeting, I couldn't help questioning whether my boss tells us everything, especially when my friends from other departments tell me some things, which I haven't been told by my boss...(Opt B j).

One possible reason behind these negative responses was seen to result from the absence of some tools or procedures required by TQM. The use of a meeting agenda and minutes of meeting as a part of the document control and the use of problem analysis tools such as FADE or fishbone diagrams were seen as important devices that allowed communication to flow purposefully towards the desired direction.

5.5. Discussion and Conclusion

This chapter discussed the role of the hospital's management in constructing a TQM influenced working environment and its effect on communication and coordination outcomes. Within this constructed working context, two particular TQM principles of “continuous improvement” and “process focus” were found to result in management's emphasis on “continuity” and “formality” in their construction which, in turn,

contributed to two key communication outcomes: (1) intensity of communication flow and (2) clarity and consistency of communication messages.

The first communication outcome was the *increase of the intensity of spontaneous, multidirectional communication flow*. The arrangement of activities, such as strategic business planning process, policy deployment, and meetings promoted horizontal communication at each working level as well as strengthening vertical communication flow across different working levels within the hospital. The second communication outcome was to the *increase clarity and consistency of communication messages*. Activities such as training and policy deployment, standardised working processes, and document control were used as mechanisms to ensure the hospital's key messages reflected and reinforced the hospital's goals and strategic directions.

These two communication outcomes were seen as supportive of coordination as it established and reinforced “shared understanding”—the key characteristic that is seen to determine coordination outcomes in this study. Based on the findings, there were three aspects of shared understanding that emerged from the study: (1) *the hospital's shared goals, vision, and mission* through mechanisms such as the hospital's annual strategic business plan and policy deployment, (2) *the hospital's policies and standardised working processes* through mechanisms such as the standardised working processes and document control, and (3) *the interdependent working relationship* through mechanisms such as meetings, morning briefs, collaborative problem solving, incident report investigation and flowcharts.

Evidence obtained from the study suggested this shared understanding context was central to creating and sustaining the coordination efforts of the hospital's staff, despite their differences in responsibilities, as well as educational background. For instance, although respondents from the operational level did not seem to have as many opportunities as those from the management level to attend and participate in collaborative problem solving meetings, they could still experience one aspect of shared understanding, the “interdependent working relationships”, in carrying out tasks within formalised working processes, or through communication tools such as TQM's fishbone diagram, a root-cause analysis tool taken to mean “teamwork” by one respondent from the operational level.

Thus, these aspects of shared understanding were underpinning coordination. It served as a common ground for translation and interpretation and allowed the hospital staff members to engage in meaningful interaction and communication, and work successfully together. Figure 5.1 summarises the management's interpretation of TQM, which was translated into the construction of the TQM influenced working context allowing the hospital's staff members to socially interact and communicate within a context of shared understanding which underpinned coordination.

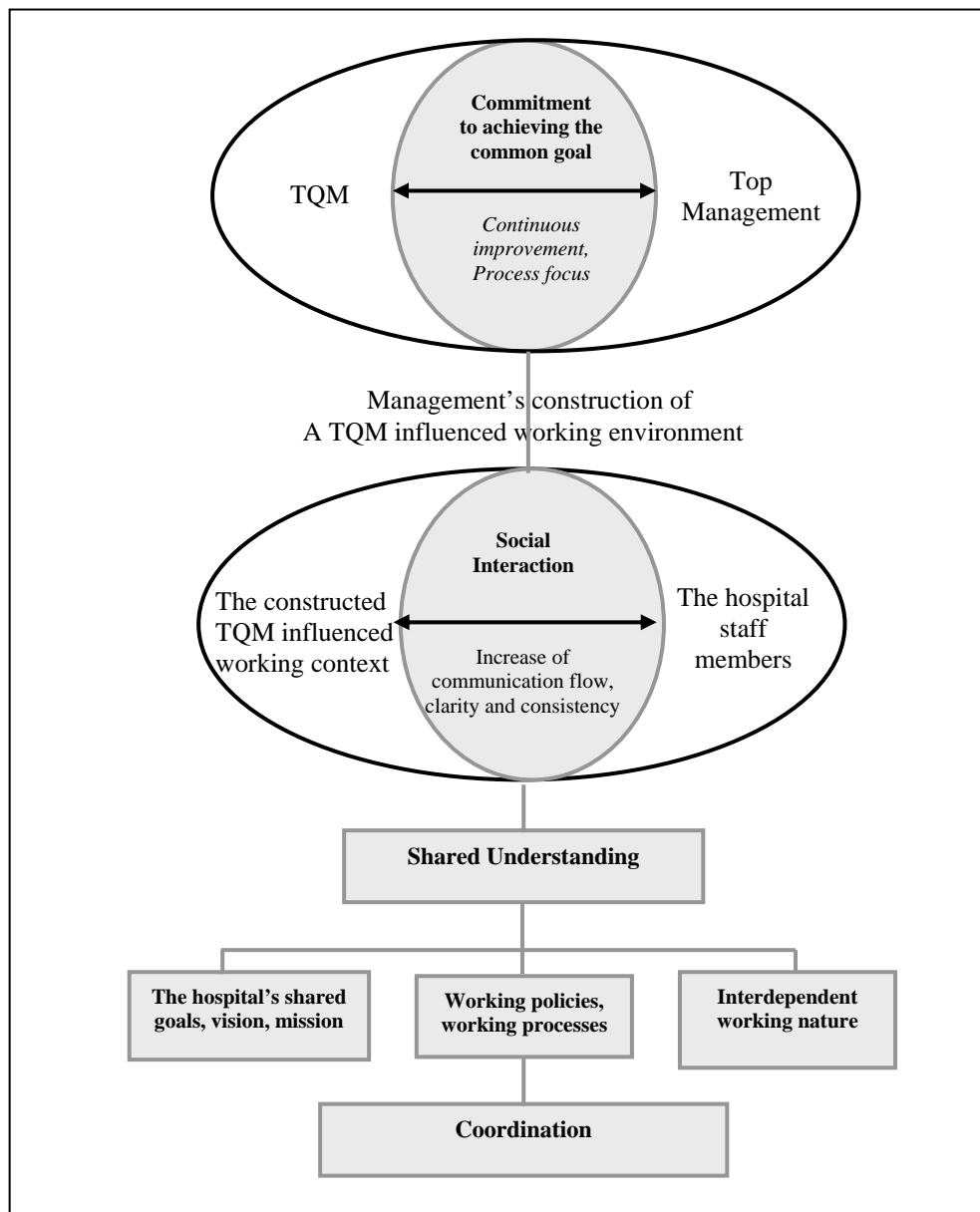


Figure 5.1: The Management's Construction of a TQM Influenced Working Environment

The emerging of the “shared understanding” pattern of coordination through the increased of communication flow as a result of the hospital management's

construction of TQM working context thus reflects that idea of Burn's (1978) "institutional embodiment of purpose", in which organisational structure and system nurture mutual understanding among employees in an organisation. Based on the existing literature on coordination, within the hospital studied, coordination was seen to achieve in two modes: bureaucratic and group.

The "bureaucratic mode" (Van de Ven, 1976) relies on standardised tasks to constrain and channel the activity of each work-unit member. The mechanisms used in the hospital studied in this mode included formalised rules and policies and procedures; pre-established plans; and standardised information and communication system. The "group mode" (Van de Ven, 1976), on the other hand, is characterised by heightened mutual adjustment based on feedback, application of high professional discretion and the exercise of autonomy. While the former mode is seen as requiring little verbal communication among members the latter was associated with frequent used of lateral communication (Gupta, Dirsmith & Forgarty, 1994).

While it was clear from the findings that coordination at the operational level was often associated with the bureaucratic mode and that management was often associated with the group mode, the observation that the bureaucratic mode requires little verbal communication (Gupta et al., 1994) seemed not to be the case. In the hospital studied, communication while carrying out tasks within the formalised processes was considered necessary, according to the responses quoted earlier in this chapter, one from each working level:

Communication became more and more a requirement...you need to be more communicative...you cannot just follow the process (Opt F I).

In order to complete these working processes, they need to communicate within their team or between their team all the time...to discuss and put together the paper work before submitting to TQM. So obviously, they talk more and see each other more, not just pass on documents along the working line (Mng B ml).

The heavy use of routines or protocols for continuous improvements (Deming, 1986) reflected the mechanistic forms of management such as centralisation and formalisation. Olian and Rynes (1991) noted that the emphasis on "process control" in order to increase consistency, reduce waste, and speed the flow of work is one of the

most frequently levelled criticisms of the TQM concept, as it is associated with the “coercive function of bureaucracy” (Spencer, 1994) in achieving coordination. Problems associated with this mode of coordination derived from the assumption that to increase the efficiency with which workers perform repetitive tasks (Burns & Stalker, 1961) or follow standard operating procedures (Cyert & March, 1992) may result in careless, unmindful, thoughtless, unconcerned and indifferent performance of the tasks (Weick & Roberts, 1993).

In this regard, routines are seen as identical to the scripted or mindless behaviour that occurs when there are event schema, categorisable stimulus clues, action rules and minimal required effort (March & Simon, 1958) proceeding through linear and sequential conversion processes (Pasmore, 1988). Routines are, therefore, criticised as undermining innovation and motivation to coordination and that employees may show little motivation to contribute to complex, non routine tasks (Lillrank, 2003). Although this form of routine coordination was used in the hospital studied, the fact that TQM also assumes that organisations should exhibit “constancy of purpose” (Deming, 1982) was translated into the administrative arrangement, of which the shared goal was embedded to reinforce shared understanding among the hospital staff members.

The influential role of TQM in creating and nurturing the shared understanding context thus cannot be underestimated for its contribution to communication in leading to coordination. This is particularly so for a large sized, highly complex structure consisting of a diverse and specialised group of people, such as the hospital studied. The findings suggest that within the shared understanding context, routines and other coordination mechanisms within the bureaucratic mode could be carried out mindfully and purposefully. More importantly, with shared understanding, it could reduce “specialisation” and “politics” which were seen as two main categories of barriers for coordination (Barki & Pinsonneault, 2005).

In their case study of coordination in a healthcare setting, Gittel and Weiss (2004) also observed that problems such as professional identities, specialised knowledge and status differentials acted as a major barrier to coordination. Although this study was conducted within a non-medical treatment working area, the established shared

understanding, especially the hospital's shared goals, was found to keep staff members from different working backgrounds such as administrative, customer service, technician and its sub-contractors such as securities and catering, able to work toward the same goals and objectives.

Overall, the role of the hospital management in constructing a TQM influenced social structure that has a significant impact on patterns of social interaction and communication and coordination outcomes is similar to the role of managers which Barley (1990) described as a "social institution", or that of "Structuration" (Giddens, 1984). Structuration theory refers to the rules and resources used in interaction which result in "regularised relations of interdependence" (Poole et al. 1985). Orlikowski and Yates (1994) observed that, in Structuration, managerial choice plays a role in the adoption of organisational structures and alignment of social context includes the distribution of power, social norms, habits, practices, expectations and preferences held by a group regarding its present and past interaction.

The notion of Structuration has an implication for the study's findings in regard to communication and coordination outcomes. According to Giddens (1984), over time, the constructed organisational structure influences employees' communication attitudes and practices leading to established codes, configured in workers' minds through ongoing acculturation, and representing workers' collective mental blueprints that guide organisational communication practice. As found in the study, the increase of quality and quantity of communication flow as a result of the management's constructed working context nurtured the establishment of a common knowledge or "shared understanding" between staff members which, in turn, allowed them to work together in a coordinative manner.

Previous literature highlighted the link between organisational structure and interdependency (e.g., Mintzberg, 1979; Thompson 1967) and suggested their relationship to communication, interaction and coordination. Thus, organisational structure has often been used as one of the dimensions of coordination by researchers in their empirical studies (e.g., Ensign, 1998; Gittle, 2000; Tsai, 2002). While the contribution of organisational structure in facilitating interaction, interdependency and communication has often been highlighted as a major source of coordination

outcomes, its other contribution of “shared understanding” has often been overshadowed.

In a study on cooperation in teamwork, Townsend (2005) found employee interactions can be either be cooperative, conflictual or simply accommodating, and the author concluded that interactions are not necessarily cooperative. Similarly, Weick and Roberts (1993) called this type of communication behaviour “heedless performance”. Therefore, the findings of this chapter suggest the need to include “shared understanding” aspect into the arrangement of organisation structure and interdependency (e.g., Mintzberg, 1979; Thompson 1967) in achieving coordination outcomes. More importantly, the findings also suggest that TQM principles such as *common vision*, *continuous improvement* and *process focus* can be supportive of such an arrangement as the notion of these principles could enable and facilitate the establishment of “shared understanding” context.

Chapter 6

Social Interaction within the Management's Constructed TQM Reality

This chapter presents “emotional experiences” as a pattern of coordination which is found to emerge from the social interaction of the respondents within the management’s constructed TQM reality, or TQM influenced working context. Given that coordination is seen as a “social activity” (Argyle, 1991), emotional experiences can be seen as facilitating or impeding coordination. The data obtained revealed patterns of social interaction, which showed a strong association with the creation of positive or negative emotional experiences affecting the extent of energy that respondents invested in achieving certain social activities. Thus the pattern of coordination identified in this chapter is related to the view that coordination is an “emotional experience” (Frijda, 1988).

A substantial number of the responses showing emotional experiences were observed to be derived from the respondents’ social interaction within two particular management constructed working contexts: (1) an institutional level and (2) a dyadic (interpersonal) level. At the institutional level, the emotional experiences were derived from the social legitimacy derived from “quality reality” and “internationalism”. At the dyadic level, they were associated with the communication behaviour of individual managers.

It is important to note that although the data obtained were sufficient to identify two distinct forms of emotional experiences and environmental contexts, these findings revealed several contradictions and tensions resulting from a dynamic social interaction. This was because the existing values arising from non-TQM realities such as national values, professional values and personal characteristics and behaviours, were found to have both positive and negative influences on the hospital staff, in their interaction and socialisation within the TQM reality.

6.1. Institutional Level: Social Legitimacy, Quality Reality and Internationalism

Although the terms *quality reality* and *TQM reality* are similar, the term *quality reality* is used in this section as the “perceived outcome” of the management's constructed TQM reality. The data obtained suggests that the value of the *quality reality* lies in the social legitimacy that the hospital received from its quality accreditation achievements, specifically one from the international accreditation institution, Joint Commission on Accreditation of Health Care Organisation (JCAHO), and that this social legitimacy had impacts on the emotional experiences of staff.

Overall¹³, respondents reported an emotional experience of “pride”, in that the hospital studied became more “internationalised” through compliance with international quality standards, and feeling of “professionalism” as respondents found that they were able to provide services or perform tasks that also met international quality standards. In addition, several respondents also reported having more “confidence” in working because they found the hospital had a reliable operational system.

The issue of quality reality was first raised by a Thai senior manager who saw TQM as an organisational change program aiming at quality improvement. To him,

¹³ This key finding was constructed from the responses made concerning the management style of the hospital studied.

organisations that succeed in implementing TQM are likely to have the same quality standards and outcomes. He commented that:

...the quality as the outcome should be the same worldwide. It's like an iceberg in the sea. At the tip of the iceberg, there is same quality culture, quality standard and quality outcome. But underneath, personal beliefs or national culture still operates and this usually interferes in the organisational change or transformation process. In some organisations, it may take time to change because these underneath cultures operate so strongly. But it will eventually change. If we look from this perspective, every organisation either in Thailand or in Western countries has to face a similar problem during the change. Two private hospitals in Bangkok also have different culture. I've been in healthcare organisations in the West, and now in Thailand and I am now a consultant to other hospitals in Southeast Asia and Middle east countries, I cannot see whether Thai culture, western culture, and other national culture is the main barrier for TQM. One thing that every organisation in the world shares in common is that people don't like changes (Mng B c).

His comment suggests an idea similar to the notion of social legitimacy advocated by institutional theory which focuses upon processes of ritual conformity, whereby organisations exhibit isomorphism through the diffusion of the standardised formal models of rational organisation form or societal institutional structure (Mayer & Scott, 1983). However, the manager's comment about "the tip of the iceberg" also implies that despite the quality reality becoming institutionalised, it can be challenged by other values from the non-TQM realities that operate beneath the iceberg. In fact, there is some evidence that these values from non-TQM realities interact with these within the TQM reality. However, these issues will be revisited in appropriate sections. In the following paragraphs, the focus is on the "quality reality" and "social legitimacy" at the institutional level.

The majority of the responses used to construct the findings in this section were obtained in regard to the management style of the hospital studied, the quality reality and its social legitimacy effect, reflects a shared value at the management level. Indeed, this shared quality reality was found to provide an environmental context that allowed staff at top management to work together, despite the fact that half of them were English-speaking staff who had different nationalities and professional backgrounds including medical, healthcare management, marketing, accountant and finance to their Thai colleagues.

An English speaking divisional director who at the time had joined the hospital for less than one year¹⁴ but had successfully restructured his division, said that his success resulted from the fact that the Thai owner and western management team were willing to make sacrifices for quality improvement. When he was asked to elaborate, he said that:

Talking from my [name of front line division] perspective, I think the culture of the hospital and its structure was really great and this is why the hospital is becoming what it becomes, a true successful international quality management company...Quality improvement is an on going process. When you are accredited, you have to maintain it. If not, you fail. Our executive team always made it clear that quality improvement is our priority and they made it clear in the hospital's vision. The clear vision of our division comes from stakeholders and key executive members. If the owner, stakeholder and executive team manage to share the same vision and that this group of people are able to work on the same vision, that's the success. For success, everyone has to work on the same ground. For other companies that I have seen, the vision from the owner and management is different. It creates conflicts and politics when this happened. There will never be a proper communication between them. But our hospital shares the vision from both sides, the owner is Thai and the management is American. They are able to create an American style of management and mix with Thai culture. This is a reason why I came to work here. It's a business of caring and compassion. Thai's caring and American management and standard is a fantastic balance (Mng F e).

The open-minded attitude of the management was likely to play an important role in the process of both achieving and maintaining the social legitimacy of the quality reality. This was especially so in the case of cultural difference. One response showed that it was the western management staff who were aware of the importance to be respected and to 'fit' into the Thai working environment. According to one western manager:

You also have an institution where you can have a boss and the boss said this is what everybody does and that's what everybody does. Here [at the studied hospital] there is much more holistic work, integrated process decision-makings. The CEO has a power to say this is how it's going to be done. No question asked and everybody does it. But that's not how it happens here. Instead, he will make sure that he has the support of all management directors on certain things before making decision. Because he knows that for a decision to be implemented effectively, then it has to be agreed to and supported by the local staff. That's what I think it's one of the big differences they do apply to this organisation...Now in terms of hospital management, I think that we are so effective in melting the best of the foreign culture and Thai culture, and trying

¹⁴ This director was included in the study due to the significant of his roles and responsibilities.

to produce something that is unique in terms of how we communicate, how we interact not only with the clients but between ourselves (Mng B r).

A Thai senior manager spoke of his role in leading the hospital's TQM implementation program after the CEO agreed that TQM would be executed in a Thai way. Based on a comment from this manager, it seems that the western management respected not only Thai culture, but also the culture of the hospital studied, where doctors had more power in leading the change through TQM. He commented:

We do TQM in a Thai way. We take the concept and follow the international standard but with Thai execution. [Since your boss is a westerner, is he happy with this approach?] They are only interested in the outcome, not the execution. They support us. They know and respect our culture and they know that if TQM is to be successful in a Thai hospital, they need to let doctors lead, and lead in a Thai way. Doctors play an important role here and the nurses seem to understand their role and play an incredible supporting role. If you let the nurses lead, it is very difficult to be successful and the nurses themselves also did not seem keen to take the role (Mng B c).

The data obtained also suggest that “internationalism” was another aspect of social legitimacy in the hospital. Given that the hospital had been accredited internationally for its success in quality improvement, some respondents saw that the hospital had become internationalised. In fact, the image of the hospital studied as an “international” hospital was widely perceived not only among the hospital staff but also by its external stakeholders¹⁵. One of the reasons behind this perception was likely to come from publicity and marketing communication activities which always contained messages on international quality standard.

One middle manager pointed out that the hospital was operated neither in a Thai, nor a western style, but in an international style. She commented:

Our hospital has an international management style, not Thai and not western. I think it's good because we are surrounded by multi-culture, not just the people who work here but also the customers who come from different cultural backgrounds. So we really need to operate in an international style...We have a very systematic working process to maintain our quality standard, a well organisational structure and a very clear line of command...I feel we became

¹⁵ Based on news articles written about the hospital studied and informal conversations with external stakeholders such as customers and hospital accreditation surveyors.

more professional when we operated under the international standard which everyone is trusting on (Mng B n).

This emerging view on “internationalism” seemed to provide a harmonised environment for the hospital staff and customers who came from a diverse cultural background. However, the following findings suggested that the notion of *internationalised* was often taken to mean *westernised*, not *globalised*. This finding emerged from the respondents' comments on the hospital's mixed management style of Thai and western methods. Interestingly, comments that were made on the western management style were often made on the issue of quality management and international standards. Responses along this line are as follows:

Western style is professional, and Thai style is compassionate:

It's a good combination, I think. We have Thai compassion and caring for our service to customer. But in terms of the system management, we have a very well organised system and process. We have a working standard to follow. I think we are more professional and international now, but with a soft Thai heart (Mng B n).

Western style is systematic, and Thai style is flexible:

We have a western management style but Thai caring service. That's how to sum up our way of doing business and that's our competitive edge. I can see that we have changed a lot during the past five years...we have to follow many quality standard systems like the international one from JCIA, Thai HA, ISO 9000 and 14000. Although the core system is maintaining the quality, but there are many working details involved in our quality system and so we need the western system management and organisation to maintain our quality system...I know it was tough for some of our staff members who prefer to work in a flexible and compromise Thai way...(Mng B w).

I like the western system as they tend to work fast and keep things on schedule. This system is good for Thais because we tend to do things at their own pace. In the past, if jobs were not done today, they would be done tomorrow, or even the next day. But with the quality system that we have now, it will not allow this to happen. Things need to be done within a certain time frame. Otherwise, the delay will show in the system. So I think people are more active than before...I think it's great that our work is now complying with the international standard. We feel more secure as well as proud to work in an international organisation...(Opt F k).

Western style is standardised and tight, and Thai style is loose:

We have a mixed management style. We have a western influence on our efficient system and process...They focus on achieving goals and commit to it more than Thais...Thais also focus on that aspect but if they did not achieve it, never mind, it wasn't a matter of death...Having a systematised working

process is good for the hospital as a whole because we know that everyone will produce work that is accepted not only at the national level but also at the international level...I heard that other hospitals are very interested in hiring our people as they know we have been well trained...[Are you interested in working with them?] Umm, at the moment, no. I cannot see any reason to leave our hospital...it may sound arrogant but I'd prefer working here because we already have a system up and run...It's a very hard to achieve the accreditation you know! (Opt B j).

The comparisons made in the above responses indicate the influential role of the values from non-TQM realities, specifically Thai cultural values, which affected the interpretation of respondents in the hospital. The respondents seemed to compare the Thai and western management style on the basis of standardised and systematic work process—that is the western tended to be more *rationally-based* and Thai tended to be more *emotionally-based* management. Furthermore, the influence of the value from non-TQM realities also was seen to allow the quality reality to be adopted in a way that fit the context of the hospital studied. As shown in the responses obtained, the mixed management style tended to be applied in a different context. That was, the Thai characteristics of softness, caring and compassion were applied in a customer service context and that the western characteristics of professional, systematic and organised were applied in the operational context. Nevertheless, several managers saw this mixture as providing a competitive advantage for the hospital.

For instance, one manager saw the hospital as a business of caring and compassion and that, “Thai caring and American management and standards is a fantastic combination” (Mng F e). Another senior manager mentioned a similar point but also pointed out that the international quality standard, specifically of the medical treatment, helped differentiate the hospital from other private hospitals. According to him:

Western people don't care much about the world class message...But in Thailand, people find world class service and medicine interesting. I think many hospitals in Thailand have a world class service. We [Thai] really have a culture for service, many hospitals that have not been accredited could have a world class service...But for world class medicine, only our hospital has been accredited under the international standard...We just bring two aspects of world class together in one place and provide value for money (Mng B c).

With the hospital's strong commitment to customers, it seemed that the Thai caring and compassion were primarily invested in building relationships with external

customers, rather than internal employees, in order to promote the hospital's world class service. This business strategy of Thai-influenced world class service, and western-influenced world class medicine was found to result in the increase of the volume of customers and profit, as well as the rapid growth of the hospital. However, the success of the hospital had some negative impacts on the relationships between superiors and subordinates, as well as between colleagues.

This is different from the functional perspective where the quality-influenced work process was seen as an effective way to maintain smooth operations, especially in a large sized hospital. Some staff members reported that their "family-like" interpersonal relationship between superiors and subordinates suffered from the quality-influenced work process. A middle manager agreed with this drawback. But, at the same time, he saw that a westernised management style was inevitable, if the hospital wanted to compete at the international level:

In the past, some Thai management people did well in maintaining good relationships with staff members. They walked around to get to know the staff, asking whether they have problems or not. If they have, they would try to help out. In doing this, employees feel they are being looked after. Now the management is more professional. And now we have more professional people coming in. But I think this is the way it should be, if we want to be at the international level (Mng F b).

One respondent from the operational level had a similar view:

Thai management style tends to be more compassion, a family like, sympathy and very understanding. We tended to work for each other and helped each other out like brother and sister. We still have this relationship but lesser...I find the western management style is very strict. Staff members are not being treated like family members. A rule is to follow, not to compromise...(Opt F pe).

The term "compromise" was often mentioned by respondents in regards to the Thai management style. Besides the above response (of Opt F pe), a manager who raised an issue about being a "flexible and compromise in the Thai way" was asked to provide an example of the issue raised. She gave one example:

...In the past, if they forgot to submit some forms or delayed the submission, it was OK as long as they came in, submitting the report and saying sorry. We used to operate in a brother and sister way. If one of your little brothers made a

mistake, you told them but you also helped them by fixing the problem and forgiving them. So they [those who made mistake] usually get away with the mistake, by just coming in and saying how sorry they were. But with the quality system, this is not OK, saying sorry is not going to help. It is considered as not being responsible and not being professional. When we do quality improvement, we expect 100%. It's like when you fly and the airline says we are 99% safe. As a passenger, how would you feel if that day the missing 1% happens to occur? So the same thing is applied here. We cannot compromise with issues like this...little mistakes or ignorance is a high quality cost (Mng B w).

The existing literature identifies “negotiation” as central to reciprocal relationships (Barker et al., 2000). These responses about “compromising” thus suggested that some Thai interpersonal relationships suffered from the western influenced working process. This may have resulted because Thai subordinates' opportunity to negotiate with superiors through the use of quasi-sibling relationship was reduced. Given that interpersonal relationships are a major part of Thai working life (Komin, 1990), it is possible that this change could create a feeling of discomfort for Thai staff. In fact, some of the responses suggest that hospital had to sacrifice or compromise on certain issues in order to comply with the requirements from quality improvement activities. This suggests a form of emotional experience based on conformity pressures from the quality reality.

Nevertheless, two respondents saw a positive aspect of the western style of management which provided a sense of equality and justice. The two responses were obtained from one operational staff member and one manager, respectively:

The Western system is good. Right is right, wrong is wrong. You cannot get away using a personal relationship in a Thai way. If you did a good job, you deserve a reward but if you didn't, you are out. In terms of working, they tend to be focusing on their own job. You need to be good at what you do, not just being nice to people. I see good and bad points in the western management system. We are now focusing more on our area of responsibility, so our relationships with other staff members tended to be limited to our working unit, instead of the hospital-wide level like we used to have in the past...Also, after achieved the international quality standard [JCIA], our hospital grew very fast, becoming bigger. So it's really hard to maintain close relationships outside our department. I think this is what we have to sacrifice for being a world class hospital (Opt F pe).

...But the good thing [of the western management] is that staff members are equally treated. It isn't something like this person could easily get out of the trouble because he is a cousin of Mr. A. So now if you are doing things in a

right way, you will have no problem. To me, that's a fair play and I feel good about it (Mng F b).

These responses suggested that the interpersonal working relationship, specifically Thai sibling relationships, were affected by the adoption of the quality working standard and system, and indirectly from the rapid expansion of the hospital business, as a result of the quality outcome. This may explain why despite some of the top management speaking of their "walking around" management style and that several employee relationship activities were organised by the hospital studied, these practices could not replace the previous Thai-based camaraderie working environment.

One respondent who has worked at the hospital since it opened said the change in the size of the hospital as well as the management system affected working relationships between staff members within the hospital.

I started working here when we had only a few hundred employees and we all worked in the same building, which was much smaller than the one we are working in now. So, basically, I knew everyone from doctors to technician staff members. It was very easy for me to ask others for helping and for them to ask me. You didn't have to make appointments; you just popped in their office and got the job done...Communication was also very good, news and information spread very quickly...we were living more like big families...we had more chance to chat and catch up to see what happen in their life and telling them about own. We talked about our families all the time, sometimes we even bring them with us to work...now the hospital has changed a lot. We have thousands of people working here and I see new faces all the time. I don't have much chance to catch up with my old friends from other division...it was funny when I met some of the old staff members by chance as we often joked each other like, What? Are you still here? This is because we rarely met. Especially when almost everything can be is done on-line. You follow the process and submit it through the system. I sometimes said to my colleagues that we could get fat. Not having much chance to walk around except for the meeting or training...That's why I am now enjoy attending training or workshops...We can contact with everyone in our office. May be in the next five year, we can work from home! It's a bittersweet really. Because, at the same time, we are also very proud to be a part of a successful, international hospital and we feel more secure to work here...(Opt F p).

Based on the evidence obtained on the overall management style of the hospital studied, it was found that the influence of the quality reality had affected the nature of interpersonal relationship in two aspects. The first was that the Thai-camaraderie working relationship was shifted towards a professional working relationship.

Secondly, the Thai-camaraderie relationship was emphasised in the context of building and maintaining relationships with customers.

However, given the fact that the responses obtained in this section were mainly derived from one of the interview questions which asked the respondents to compare the hospital management style before and after achieving hospital accreditation, the pattern of change in the hospital's management style which was found only provided one part of the reality of management at the institutional level. Despite this, the finding suggested some contradictions with those obtained from the dyadic level. While the findings from the institutional management level suggested that the quality reality dominated the management style at the hospital, those obtained from the dyadic level showed that managers still exhibited behavioural characteristics that were influenced not only by the TQM reality, but also by other realities such as national values, hierarchical status, professional culture as well as individual values. These findings are the main focus of the following section.

6.2. Dyadic Level: Managers' Behavioural characteristics

This section presents the behavioural characteristics of managers in the hospital which were found to energise or impede subordinates' effort in communication and interaction with others. This section, however, begins with the overall behavioural characteristic of the hospital's management, specifically in regard to communication climate of the hospital. To obtain the overall impression of the hospital's communication climate, the responses were analysed based on Gibb's (1961) supportive and defensive climate framework which categorised two opposite types of communication climates in organisations: *defensive climate* and *supportive climate*. Within each type there are six categories of behavioural characteristics (see Table 6.1).

Gibb's framework on the behavioural characteristics of leaders was relevant to the key finding of this study which identified the significant role of leaders in constructing the TQM reality. Thus, the findings obtained from Gibb's framework were useful for the further analysis on characteristics of managers that enhanced or

impeded coordination outcomes. Table 6.1 provides the frequencies recorded from the responses obtained based on Gibb's framework. Since the frequency of the coding was recorded based on incidents or issues that was reflected the key characteristics listed in Gibb's framework, in this study, "frequency" was treated only as guidance for identifying significant issues.

Table 6.1 : Gibb's (1961) Defensive and Supportive Communication Climate

Defensive communication climate		Supportive communication climate	
Behavioural characteristic	Frequency	Behavioural characteristic	Frequency
Evaluation	3	Description	6
Control orientation	11	Problem orientation	13
Strategy	4	Spontaneity	5
Neutrality	1	Empathy	22
Superiority	12	Equality	19
Certainty	5	Provisionalism	3
Total	36	Total	68

The responses obtained suggested that, overall, managers¹⁶ of the hospital studied had characteristics that belonged more to the supportive communication climate than to the defensive category with frequencies of 68 and 36, respectively. Within the supportive communication climate, the behavioural characteristic of "empathy" received the highest responses, followed closely by "equality" and "problem orientation" with similar frequencies. Empathetic words indicated that the superior staff members were responsive to subordinates' feelings and thoughts such as *understanding*, *concern* and *show interest* were often mentioned by respondents. As for the behavioural characteristic of "equality", managers were reported to *trust*, *listen* and *share information*; whereas the behavioural characteristic of "problem orientation", managers were often reported to *invite subordinates to share ideas or discussion* and *seek solutions from subordinates*.

As for the defensive communication climate, it was found that the behavioural characteristic of "superiority" and "control" received the highest frequencies. In some responses, managers were reported to make their own decisions and asked their

¹⁶ For this context of this study, "managers" were taken to represent "respondents from the management level" including top managers, middle managers, and supervisors. Responses that reflected characteristics of these managers were received either from the managers' comments, or from colleagues and subordinates whose responses were made in reference to "managers".

subordinates to follow the decisions made without any explanation. Or, despite listening to subordinate employees' ideas or problems, some managers did not take any further action. Overall, most of the responses obtained in this defensive communication category seemed to derive from "inadequate feedback" from managers which tended to create negative emotional experiences to some subordinate staff members as they felt ignored by their superiors.

In addition to this, the responses obtained also revealed a significant issue of the influence of some Thai characteristics concerning both supportive and defensive communication. More importantly, in some of the responses both the characteristic of Gibb's supportive and defensive communication seemed to be operating within the same context and this showed some contradiction in the findings. For instance, it was found that some superiors used their "superiority" with "empathy"—some managers made a decision in consideration of what should be best for their subordinate staff and without a discussion with the subordinate. As a result, it caused misunderstanding between the two parties. This example suggests that analysing data using a pre-prescribed framework like the one from Gibb may not be flexible enough to provide a good understanding of the fluid and dynamic relationships between staff members within the hospital.

The fluidity and complexity of relationships in the qualitative data suggest that using the result from the questionnaire survey, which measured communication climate at the hospital, as a secondary data source to support those from semi-structured interviews was appropriate for the study's inquiry. Nevertheless, the result obtained from the questionnaire survey showed that, based on the impression of the hospital communication climate which was perceived by the wider group of respondents, on average, the score of all sections of the survey fell in the "satisfaction" category, including those of statements on superior and subordinate relationships. This quantitative finding was thus consistent with the qualitative result from Gibb's framework which suggested that, overall, respondents perceived the communication climate at the hospital studied as "positive" (see Appendix C: Questionnaire survey results for a full report on communication climate).

The focus now turns to two key emerging themes obtained from further investigation on the initial finding obtained from Gibb's framework. At this stage, the data analysis follows the notion that coordination is an emotional experience (Frijda, 1988) and that emotions and moods help to coordinate an individual's behaviour and responses (Cosminde & Tooby, 2000 as cited in Spoor & Kelly, 2004). Thus, the two emerging themes to be presented here were based on behavioural characteristics of managers that created (1) positive emotional experiences or (2) negative emotional experiences for their subordinates to engage in communication and interaction with managers, work colleagues or customers.

6.2.1. Positive Emotional Experiences

Overall, the findings obtained in this section suggest that the effect of the TQM reality on managers' behavioural characteristics that created positive emotional experiences for their subordinates mostly occurred in the responses recorded within Gibb's "problem orientation" behavioural characteristic. The findings indicated that the values from non-TQM realities, especially those related to national, professional and personal traits, tended to have more influence on the responses recorded in Gibb's "empathy" and "equality" behavioural characteristic. The following presents managers' behavioural characteristics that created positive emotional experiences, which can be broadly grouped into two major influences from (1) TQM reality and (2) non-TQM realities.

6.2.1.1. TQM Reality

Almost all of the responses reflected the "problem orientation" behavioural characteristics of managers were found to be made in reference to *customers*. In chapter Five, the effect of TQM on the improvement of upward communication was highlighted from the influence of TQM principle of problem solving and continuous improvement on the administrative arrangement of feedback gathering mechanism. However, in this chapter, the TQM principle of *customer focus* was found to play an important role behind managers' act of "problem orientation" behaviour characteristic. Based on the responses obtained, managers reported or were reported to obtain information and feedback from the operational staff members, especially those from the front office. For instance, one manager saw that listening to the frontline

staff helped with the alignment of the internal supply to meet the “external customer expectation”, according to his comment:

I'm more concerned on feedback...People in the front line have more chance to contact our customers so they know what the customers needs, what are the changes that occurs, what problems we face...The best role of the management people is to align attitudes of our external customers and internal staff members to be on the same mindset...(Mng B c).

The inclusion of front-line employees in problem solving is well addressed in TQM literature as a crucial source of ideas about how to improve operations that directly impact the quality of outputs (Hackman & Wageman, 1995; Lawler, 1994). At the hospital, the focus on learning about customer problems was central in the attention of frontline managers who often made similar comments about always keeping their communication line open so that “customer-related” problems could be solved on timely basis. One manager said that even when her subordinates did not come to her to report problems, it was still important to do follow ups because, according to her:

...in this way, I could know how they go about doing things...there were some issues that they brought up as a general report that raised my concern. They may not yet see or feel at that moment that it is a problem. But soon it will be a problem...This is how we could have a proactive approach to providing a quality service to customers (Mng F j).

This management practice on seeking feedback or following up issues was found to create a positive energy for the front office operational staff members who often reported they felt themselves to be valuable because, for instance, “My information is valuable for the management (Opt F c)” and that “We play a very important role here...the management needs us because we provide service to customers (Opt F l)”. In addition to this, the use of the morning brief, which had been introduced for about a year by their divisional director as an informal forum to solve problems and coordinate daily tasks satisfied the frontline staff, given that it was included in their responses to the interview question on the communication strengths of the hospital.

The frontline staff saw the morning brief as allowing them to have timely feedback and responses from managers on current issues or problems. For instance, one of them said the morning brief was “the place where our voice can be heard (Opt F l)” and “I feel I have been supported and being understood (Opt F t)”. Two others reported their

satisfaction with managers' responses because it allowed them to perform their tasks better:

It really helps with my performance. I'm not stuck with problems for long. If I report to my supervisor before the morning brief, pretty often that I will have feedback within hours...I really appreciate it. I feel we are really professional...(Opt F m).

I'm very happy with the morning brief. It's great, especially it allows us who work at a frontline and at the operation level to communicate upward problems we face, and to have quick feedback and a solution back. Before when we reported problems upward we had to keep waiting and waiting and, as a staff member who faced the problem, I felt frustrated. It's not easy to do your job when you still have no solution and you cannot make your own decision as it's beyond your authority (Opt F p).

The positive experience of being able to share information as well as being supported by managers through the use of morning brief was likely to nurture a sense of togetherness. This was because responses such as "we are a great team (Opt F m)" and "we feel we are in this together (Opt F c)" were heard from the frontline staff. In addition, the frontline staff tended to have more opportunity to be empowered to make decisions than those operational staff from the back office because, according to one manager, "they directly serve our customers" (Mng B c). Another manager said that the hospital was trying to empowering its staff to make ones' own decision, according to him:

...we are trying to install a model where each staff member has power to make decision or solve problems. And even if they are wrong; it doesn't matter. If customers are not happy, for instance, from waiting a long time for a laboratory result, the frontline staff member can fix the problem...[such as] they can make an inquiry to supervisors of a particular unit that keeps a customer waiting, explain to a customer the cause of the delay, and give them a complimentary voucher for customers to go and have some refreshment at Starbucks or other food outlets in our hospital. And when the result is in, they give the customer a call...(Mng F p).

It seemed that this management strategy had already been practised among customer service officers. One of them supported the idea of empowerment because it allowed her to handle complaining customers effectively, according to her:

[Being allowed to make her own decision is] the best way to keep our customers happy. I don't have to go and look for my supervisor for her permission on issues that I know she would agree and approve. So it's less troublesome and allowing me to handle complaining customers better...I think the customers also happy because sometimes I notice that they also felt

annoyed to hear me saying, please wait. I'll be back in seconds. I'll talk to my supervisor. When hearing this, some customers often said why I don't let them talk to my manager directly, which makes me feel a bit powerless...(Opt F 1).

In TQM literature, empowerment is often interpreted as a way for management to encourage participation and commitment among employees by providing a sense of autonomy and that some empirical data provides support for the claim that worker empowerment increases motivation and job satisfaction (Anderson et al., 1994; Locke & Schweiger, 1979; Monge & Miller, 1988) and that output quality may improve as a result (Dean & Bowen, 1994; Hackman & Oldham, 1980).

However, Waldman (1994) argues that empowerment can be interpreted in a different context. He argues that "some people may perform better on a traditional assembly line process with autocratic management, whereas others respond better to team-oriented assembly methods and high involvement by management" (p. 517). The finding of this study supported this view because it found that in the hospital, empowerment in the sense of providing a sense of autonomy at the operational level staff occurred only in a customer-service context. More specifically, the frontline staff seemed to be allowed to make their decisions within a context of keeping the customer satisfied during their hospital visit.

If one takes a view of empowerment as a sense of job autonomy, the management practice of the hospital can be criticised in a view similar to that of Hackman and Wageman (1995) who saw "the distribution of authority in organisations typically does not change much when TQM is implemented" (p. 337). However, this study saw that the notion of empowerment needs a different interpretation, specifically in regards to the working level of the hospital staff. While the findings of this study suggest that empowerment through a sense of job autonomy was appreciated by managerial staff, empowerment through communication of social support such as sharing information and providing feedback was likely to be appropriate for operational staff members at the hospital. This view of empowerment through social support is supported by Ashcraft and Kedrowicz (2002) whose empirical data obtained from their study of a non-profit organisation providing shelter and counselling for domestic violence survivors led them to conclude that empowerment meant more than autonomy.

Ashcraft and Kedrowicz (2002) advanced a “feminist” interpretation of empowerment as an outcome of organisational social support by arguing that volunteers experienced social support from paid staff members as “empowering”. More specifically, Ashcraft and Kedrowicz also added another important point relevant to the context of empowerment at the operational level of this particular study. They suggested that with respect to particular task requirements in which personal competence may be limited, social support enables employees to feel better able to respond to challenging responsibilities. This point reflected the finding obtained in this study, in that some interview respondents from the operational level said that they were happy to be told how to perform their job. If they were faced with a more challenging and open organisational climate environment, they may be overwhelmed and be less productive.

Nevertheless, the emotional experience among the operational staff members as a result of empowerment through communication social support was found to occur more in the “customer-related” problem-solving context than in the employees’ work-related context. For instance, some forms of upward communication were arranged by the management to receive feedback from staff members about their work-related problems. However, it was found that this practice had not yet provided useful results. More importantly, it was also found that the two parties seemed to have a different view—while management saw that they had made their best efforts to obtain feedback on work-related problems from the hospital employees, the employees, especially those from the operational level, were reluctant to use this arrangement to its full potential.

For instance, a senior manager from the back office talked about the implementation of “exit interviews” which was seen as an important source that the hospital could obtain work-related problems and improve its internal operation, according to this manager:

...the management is more concerned than before on issue like quitting jobs because it is also a part of our quality improvement goal. We want to find out the reason why employees quit the job so that we could find proper solutions...Employees who resigned tended to have no pressure in telling us

the truth, or some issues they find difficult to tell us if they are still working here (Mng B k).

Interestingly, the researcher spoke with one staff member whose job allowed her to closely observe the implementation of the exit interview. This person felt that the management may not discover the real reason behind an employees' resignation:

It's a good idea and I support the idea because at least management people showed their good intention to know and want to change things for better. But the problem is, I feel that the management may not always have the truth from those who left the hospital especially those who left the hospital unimpressed with management. I don't think they will tell the truth except for the ugly messy case, which is quite rare. I find staff members who left tended to keep the real reason to themselves and used some polite reasons such as further education, family problems, or their health instead (Opt B k).

Another issue about problem solving in the staff members context was found in the responses made on the health and welfare committee which was set up for the hospital's employees to obtain problems and feedback from employees (Scope of Service: HR 3.06). Some respondents who were previously involved, or at the time of the study was one of the committee members reported difficulties in raising problems and ideas, asking for following up, and negotiating with managers who represented the hospital management team. These difficulties caused this ex-committee member a negative emotional experience. He commented that sometimes he felt:

...It may not necessary to have me in the committee. I didn't see the difference of having me in the committee (Opt F p).

His comment mirrored what was found in an exploration which investigated key factors behind employee remained silent which interviewed 40 employees. Based on the data that they obtained, the researchers argued that "...even though problems may be significant, employees may still be reluctant to speak up if they feel that there is no hope of remedial action and discussion would be futile" (Milliken, Morrison, & Hewlin, 2003, p. 1468). However, another respondent, who had a similar experience of feeling of helplessness about voicing his ideas in meeting, made a suggestion on having a representative in the committee; as he said:

I want someone who shared the same feeling and understanding of our problem to represent me. I can collect all the feedback and problems from the operational staff members and gave to the person who can speak up in the committee meetings (Opt B s).

The above response suggests that, besides the fact that management may not handle bottom-up communication messages properly, the difficulty in communication within a work-related, problem solving context may derive from a Thai characteristic of *Kreng Jai*. *Kreng Jai* is described as extreme reluctance to impose on anyone or disturb his/her personal equilibrium by direct criticism, challenge or confrontation (Sriussadaporn-Charoenngam & Jablin, 1999). In this study, *Kreng Jai* was often found to be associated with characteristics such as avoiding direct communication and confrontation, especially when it was related to the respondents' own problems.

Interestingly, the communication behavioural characteristics of *Kreng Jai* were found to appear in a lesser degree within the customer-related, problem solving context. Operational staff from both the front and back office often reported submitting issues or concerns that were related to customers' interests, despite the fact that, in some cases, this created conflicts or tensions either at the interpersonal or interdepartmental level. One operational staff member from the back office said that he sometimes wrote incident reports when he saw mistakes that should not occur because it "affects our quality services" (Opt B s). When asked if his acts would cause conflict with a person who was affected by his report, he replied that:

We have to do it. It's not about the name-and-shame thing. It's about reporting problems so that our management people can fix them. If someone submits a report on my error, I may feel guilty, but I wouldn't upset about it...most of the time, there are many causes that contributed to one particular problem. So it's not fair to blame the whole thing to one, particular person (Opt B s).

This response reflected an idea that was emphasised by some managers who tended to take a rational approach to problem-solving. One response obtained from a manager suggested his way of solving problems was based on a process-focus perspective that:

When we do TQM, we focus on process, not on people. When problem occurs, we fix the system...If customer makes a complaint about our staff members' manner, we organise a manner workshop...(Mng F c).

Another example showed that the staff members at the hospital may feel comfortable to report problems when the problems were handled rationally. A manager directly involved in the hospital's quality improvement management who observed an increase in the number of incident reports submitted to her division commented:

When the report system was introduced, we received less than 10 reports per month. But now we have up to a hundred per month. This is because they [staff members] know that they will not be in trouble from submitting the incident reports. There is no punishment involved...it is a collaborative process that everyone provides inputs and helps improving our quality service by submitting the incident reports...(Mng B ml).

Based on these responses, it could be that staff members would get involved in an environment context where staff members socially interacted based on a “normative and informational cues” (Lee, 1997) that were made salient to them by management—that problems are welcomed and would be handled rationally.

6.2.1.2. Non-TQM Realities

The responses obtained on the positive emotional experiences regarding the non-TQM realities were mostly found to reflect Gibb's “empathy” and “equality” behavioural characteristic of managers. These indicated the importance of cultural influences such as national, professional and personal traits in contributing to the creation of positive emotional experiences among subordinates. This section begins with the finding on managers' behavioural characteristic of empathy and is followed by those of equality.

6.2.1.2.1. Empathy

Among the three behavioural characteristics of managers, the behavioural characteristic of the expression of empathy was seen to provide the most positive emotional energy to subordinates in investing their time and effort in accomplishing the assigned tasks as well as the hospital's goals. The terms such as *understanding*, *Song-Sarn* (pity, feel sorry for a person and want to help that person), *sensitivity*, *compassion* and *concern for another person's feelings* were often used in the responses obtained.

The hospital's decision to adopt TQM as a business survival strategy instead of laying off its staff members was the best example of an empathetic effect to encourage staff members to invest their ability and effort in achieving TQM implementation and accreditation. It was the empathetic characteristic that led to enthusiastic and devoted words such as “won employees' heart” (Opt F n), “we want to do our best” (Opt B p), and “I give a 110%” (Opt B s) were often found in subordinates' responses.

A secretary of a senior manager said that she had to be more patient and put up with pressure from other staff members during the first stage of TQM implementation. However, her manager was the reason to keep up with her work:

Quality improvement is a hard job. It requires a lot of patience. We need to understand that they [other staff members] also have extra work to do. So I have to be more considerate and use a soft approach with them, especially when we need them to do us favours...If we need to collect some documents or follow up the work process, we need to talk to them nicely. Saying things like, *Pi* or *Nong* [Thai pronoun for elder or younger sibling], is it my turn in the queue yet?...I'm lucky that my boss is very supportive and always cheers me up. When I got pressure or complaints from the operational level, my boss show her understanding, she doesn't give me more hard times. When my boss is upset, she won't let it show on her face. She just stay calm and says never mind. This is why I really have to do my best for her, to reduce her burden (Opt B p).

It was clear to the researcher why this respondent talked highly about her superior. This was because the empathy characteristic of this manager mentioned in the response above was noticeable during observation from the direct interaction between the researcher and the manager herself, as well as from her interaction with her work colleagues and subordinates (Observation fieldnote, October 5, 2004). In fact, the interaction between this manager and her subordinates could explain why they shared a similar attitudes and behaviour. For instance, in the interview, when asked what is considered as good communication, this manager commented that:

...to communicate in a polite way and, using nice-to-hear language. Even when giving feedback, we should do in a soft way. Don't be too straight and using harsh words when people make mistakes and when they do good things, give them compliments (Mng B w).

This empathy characteristic seems to be adopted within this manager's division. During the time spent within this division, both managers and subordinates showed a caring and supportive attitude towards each other. For instance, when one member was about to go another work unit, they would normally ask their colleagues if they wanted to pass anything to a person in another unit, or wanting something back from that working unit (Observation fieldnote, October 6 2004). This attitude was likely to be another factor behind the hospital's TQM success.

Another example of putting a person with empathetic characteristics in the right job was observed from a manager in charge of employee relationship activities.

Throughout the interview, words and expressions of caring and enthusiasm to work with others were common. However, one issue was particularly relevant. It was found that her sympathetic attitude and behaviour had an influence on the preparation of messages sent to the hospital's staff members which allowed her to not only maintain good relationships with them, but also to obtain cooperation from employees. According to two of her responses:

We want to communicate about people doing good things to recognize their hard work. I've been involved with the project since its first day. Everything has a meaning. For example, we choose pink because its caring and warm feelings. We choose a silver star because it represents something very valuable and distinctive. We carefully write the wording...This program has been supported by and cooperated with various staff members from different working units. They joined us as a committee and they devoted their time despite their busy day to day work. It was a volunteer job which involved hard work and extra working time. They need to walk around to observe staff members who have been nominated...staff members are really keen to participating this program and I find it also affects their service behaviour too...(Mng B wl).

When we organise activities, we need to constantly communicate with them for both their understanding and their cooperation. For example, this New Year party theme was "cowboy night" and we held at night in a large night club. Given alcohol were served, we needed to make sure that it was trouble free, either from gatecrashers, or some drunk employees. So we had so many rules and conditions for entry and having ID check...setting rules for a party may sounds ridiculous for some employees. We were so worried that they might get a wrong message. So I did some test runs, to make sure our messages did not offend people...we need to find a proper way for communication so that it creates both understanding and cooperation from the employees...[also] when we organised some sport events like a golf tournament which may not appeal to everyone. But we invited everyone. Whether they want to join or not, it doesn't matter. What matter is to show them that we care about them and continually organise activity for them (Mng B wl).

There was some evidence obtained that suggested that some respondents were willing to be cooperative with, or help the persons whom they did not know well, just because they felt sorry for that person. For instance, when they heard that one employee had had a nasty accident, one respondent said that he felt really sorry for her and wanted to help that person in some way:

I heard the secretary of [division's name] had an accident. I haven't met that person but we have talked on the phone. My department and her department need to prepare some statistic record every month. I usually do my part and send to her department to finish the other part. But after I heard about her accident, I tried to put in data as much as I could for her part and left some

tasks that I couldn't do for her to finish up. Although she can work now, if she has less work to do, she can go home early and have a rest (Opt B s).

It was found that good stories could deliver some emotional effects, which could be heightened when the sympathetic acts of top management were involved. In an interview with an operational respondent, who seemed to be a devoted employee, he shared with the researcher a few good stories that he heard about the top management, although he rarely had contact with them:

Our management like [senior managers' name] have a high reputation; people tend to listen to them and respect their decision. For [senior managers' name], I have never talked to her personally but I heard lots of good thing about her. One day, she walked to the car park and my boss heard that she said to the people who came with her that these security officers worked very hard, they should be rewarded for their hard working. When my boss told us this we were very happy that management saw us doing a job. But not long after that event, we had bonus like other employees. We were over the moon because it was something we had never expected (Opt F o).

Another operational staff member shared a story about the CEO who said he would move on to the next job if the hospital had fully operated on its full capacity of 550 beds:

Our 550 beds have been occupied for years, but he still here. I don't think he will leave. He loves working here and we love having him. I find he's smart and cool. So many media came to interview him. CNN has just interviewed him too. I think the owner doesn't want to lose him. [Have you had a chance to talk to him?] umm, not really but he said Sawasdee [hello] to me once. He understands some Thai language, I think. Usually I see him walking around. He smiles a lot but he looks quite busy...(Opt F d).

It seems that, to some subordinates, good stories and recognition through observation of another person's sympathetic characteristics did create a shared emotional experience which makes it more likely that these respondents would invest more of their energy if they had a chance to interact or communicate with the person whom they heard about. Developing an impression of a person mainly from their appearance could be difficult for newcomers, especially for those who may not express caring attitude well. A response obtained from one respondent seemed to suggest that newcomers whose characteristics could warm employee' hearts are likely to "fit" in:

Some managers came in and wanted us to do this and that but never smile and talk nicely to us. We did the job for them anyway, but they did not win our heart. [Is smile an important character for a good manager?] Not really, it's hard to tell. It's about the feelings, we can feel it. Not all managers are

generous and smile a lot though. They are some good and bad managers. We talked about the good one because we like them and we are lucky that our manager is in the good manager group...It's really hard to tell. I know some managers who don't smile and don't appear to have a sense of humour. But surprisingly, their subordinates love them. [Could you explain why?] They tended to protect and fight for their subordinates...(Opt f p).

Interpersonal relationships are addressed in both academic (Komin, 1990) and professional (Mulder, 2000) literature a fundamental element in Thai working relationships. Thus, showing empathy, intimacy and supportive characteristics were likely to be the key characteristics that managers should have, if they are to win their Thai subordinates' hearts. This cultural issue seemed to be understood among English-speaking managers. In fact, responses obtained from all of them showed their sensitivity and understanding of Thai culture that influenced the way Thai staff communicated and interacted with each other.

One operational staff member who was Muslim said that she appreciated that management allowed her to dress in her traditional dress with a head scarf. According to her, "The management here is very respectful on cultural, religion differences. They try to compromise to have all nationalities work in a harmonious environment. That's why I'm very happy to work here" (Opt F m). An American senior manager said that sometimes he felt awkward to hear two of his western colleagues talking to one another in a soft Thai way. However, he said it was because:

We have to be receptive and sensitive to how they [Thai staff members] communicate here. It's really important for management here. If we never get used to do that [soft and indirect communication], we will never get any way with our Thai staff members...(Mng B r).

The fact that foreign managers understood how to work successfully with Thai colleagues and subordinates was likely to result from their long experience working in Thailand. Three foreign managers who were interviewed in this study had been working in Thailand between 8 and 20 years. Therefore, they were well aware of Thai culture and its influence in the way Thai staff members interacted and communicated. If they failed to understand the cultural aspect, foreign managers tended not to stay long, according to one Thai respondent from the operational level:

Our problem with the foreign bosses was that, sometimes, they did not want or try to compromise. We [Thais] may take things a little bit easier, a bit more

relaxed. But that doesn't mean we are not doing the work. They don't have to loosen up a lot. Just a little bit. Actually being strict is also good for us; we also need to be disciplined. If they did this [loosen up], it would work out really well, like some other successful foreign bosses did. We are simple and very easy going. If they come to us and ask us to do their favour in a soft way, we tend to do our very best (Opt F p).

In practice, the suggestion from this operational staff member for foreign managers to be more “compromising” and “to loosen up” in fact requires an in-depth understanding underpinning the act of compromising. In other words, if the foreign managers are to act on this advice, it has to be taken from a cultural perspective, which is a cultural compromise. Thus, one aspect of the empathy behavioural characteristic of foreign managers found in this study was that they were well aware of and respected the national culture in which the hospital operated and this characteristic was evident from direct observation as well as from their responses. The response below was one obtained which suggested that the ability of foreign managers to make cultural compromises was one of the key factors behind the smooth restructuring work of units and division.

By understanding the culture, it means everything in communication. It doesn't mean Thais have to adapt for me but I need to adapt to Thai culture. I need to find my way to make sure that I am able to be understood and that I'm able to communicate with a different people...[creating] a link of community value is very important in Thai culture. If you are dealing with a group of 15 managers and those people supervise 700 hundred people, I need to create a certain atmosphere, to create an environment that creates a group and allows them to work along together...I think this is the aspect of what the management should achieve here. All you need most is to combine these people who used to work independently, putting them together and creating a team (Mng F e).

Cultural compromises also included getting to know the subordinates' personal life, and protecting them with the authority and resources that managers have. This was an aspect pointed out by another foreign manager. He saw that relationships between managers and subordinates were based on “personal loyalty” in that both parties were in a give and take relationship:

Thai management is like a pyramid, where people at the top are responsible to people underneath them. But the person at the top of this pyramid is like an autocrat or a god-type figure. Thais talk about loyalty; loyalty to your staff members and loyalty to your boss. It's a personal loyalty. In the Thai management system, you also need to know a lot more about the personal life of your staff members; knowing about their concerns, their worries. Be involved in their life...I am expected to know if one of my staff members is in trouble, and I am expected to help by talking to somebody at my level who

knows somebody who can help fix the problem. I'm also expected to know whether one of my staff members' family members is sick and help them. I have to make sure to use my influence such as money or authority to help them. But in the west this does not happen. In the West, you will be in trouble if you inquire into your staff members' personal life too much...In the western culture, the people at the management level are more loyal to company, not to the individual, or your job supervisor. But Thais are more aware of the person, it's more a personal thing. But that's the way to work with them and to have their loyalty (Mng F p).

Nevertheless, gaining cooperation from subordinates through expressing empathy characteristic may not always work. Some responses showed that some managers who were perceived by their subordinates as being a nice person did not succeed in creating a sense of togetherness within the work unit:

We used to have a very lovely and generous boss. People love her personality and she is very good in creating relationship with others. She is quite a popular person actually...but I think she cannot guide us when it comes down to work...not as much as we wanted her to do. I mean she is helpful but we want more than an emotional support. We want someone who is nice but is also good in managing tasks...We cannot blame her though. It's just that time we didn't have a clear working scope and not yet have a good working system during the time she was with us (Mng F j).

There was some evidence of the disadvantages of the empathy characteristic. Two of the responses revealed that the intimacy and close relationship that managers built with their subordinates encouraged some subordinates to conserve their energy, rather than to invest it in helping their superior to achieve the tasks. Some subordinates were reported to shirk responsibility towards work because they felt loved and protected by managers. One staff member provided an example of subordinates who took their superior's empathy for granted:

When we have a new project, we will start to hear excuses for not wanting to get involved, like saying not having good knowledge and if they got involved in the project, the boss will have to correct so mistakes for them. So they don't want to trouble the boss...Or, they may get involved in the project but didn't do much, because they know our boss will do it for them (Opt B s).

Another respondent raised a similar issue and pointed out that some staff felt too comfortable and did not put in their best effort because they knew that their superior will help them and will not report bad things to management. Finally, it was found in some of the responses, "customer" was found to be a drive behind the acts of empathy some managers. This practice was observed from two of the responses obtained:

We are so happy that management care about us. They renovated our room and installed new working equipments for us. I feel really happy to work in a new, high-tech working environment. In this way, we could provide better service for our customers (Opt F p).

My manager always asks us what can he do, or providing us so that we could serve customers better. Actually we always want to provide good service to customers, even though he doesn't provide us things. But what he does is very supportive. It make us realised that what we do on our daily basis really means a lot to him and to want to help him more (Opt F t).

These management practices can be interpreted from a critical perspective to mean that management used their empathy as a hidden agenda or as a form of exchange relationship. However, this study saw this practice as a form of *give-and-take* relationship, one of the characteristics of engaging in interpersonal relationships in Thai culture.

6.2.1.2.2. Equality

Responses obtained in this behavioural characteristic involved words such as *open-minded, listen, welcome ideas, respect, equal, trust, share information* and *decision making*. While these terms were used by respondents from the management and operational level, it was found that there was a different pattern of the effect of the act of equality of managers on the emotional experience of subordinates between those who were managers and those who were operational staff. Another interesting finding emerged from the responses obtained on the equality characteristic of managers was that, despite a different pattern of emotional experience being observed, responses obtained from both groups were often made on comparing Thai and Western management style in that the western-influenced managers tended to show their equality behavioural characteristic more than Thai-influenced managers.

Responses from the respondents at the management level indicated that they were used to being treated equally and that they were allowed to make important decisions without interference from their managers. Many often commented that their managers focused on the outcome or, "...wanted to hear solutions to the problems I reported" (Mng B w). Most of them also reported their satisfaction towards communication at the management level. For instance, one manager said:

My boss is quite open and very approachable. When I have enquiries or anything, I just go to her room and talk. I can also do the same thing with the

CEO. So there is no barrier with communication at a management level (Mng B k).

Another manager showed his admiration for western management, specifically for their open-minded, equality attitude:

One thing I really admire is our western management team they have a very strong leadership and adapt so well with our hospital. They try to get close to us and respect us. I admire their capability in managing our hospital both their knowledge and experience in healthcare and their leadership ability. They are open-minded and supportive. This character is a little bit different from some of Thais who are not welcome ideas or opened up especially for comments (Mng B t).

A few managers saw that part of the fact that upward communication was still a problem for the hospital studied was because of the attitude of some Thai managers who had not yet opened themselves up to ideas and feedback, specifically from junior staff members:

The top management put their trust on me and allows me to make important decisions, just inform them about the decision I've already made. Thai culture tends to be a top-down communication. It's getting better nowadays for a bottom up communication. But it has not yet common. People who try to get their message up sometimes are seen as being a hard head. I think it will take sometime for changing this mindset. We need to build a new culture that welcomes feedbacks, especially from bottom-up. People are more open in making their points. We are having more opened-up discussions than before. Our working style is more westernized now. Before people especially juniors tend to follow whatever the seniors say and do. We hold on to the Thai proverb saying that follow the senior and you won't be bitten by a dog (Mng B w).

While this group of managers reported their appreciation and satisfaction, the impression obtained from their responses and reaction from the interviews suggested that these managers were used to being treated equally by their managers. This finding was in contrast to the group of operational staff whose responses often showed enthusiasm and devotion when they experienced management acts of equality. One of the most admiring responses toward his foreign manager was from a security officer, as he commented:

I think he [his up-line manager] has great character, personality and charisma. He is very approachable. In fact, he tends to approach us first. I still remember on his first day here, he came to talk to me first. At that time I didn't even know that he is my new boss...When he wants to teach us something, he will do it first. For instance, punctuality. He is always the first one in the meeting...Before our division was not so active. But when he came in, our staff members have to catch up with his pace. He shows us that everyone is a team

member and there is no exceptional rule for the boss. Managers now have to work on the weekend because we have customers everyday and problems can occur anytime. Problems cannot wait to be solved. He also put his name in a weekend shift. When we have managers around even on the weekend, we feel being supported and have more confidence to deal with problems...(Opt F g).

Although not directly interacting with her divisional director, one respondent said that she put more energy into work when she learnt that her manager was receptive to her messages:

He [a division director] listens to us. I know this because when I raised some issues or problems to my supervisor, either my supervisors get back to me or I saw some changes happening. So I think he should be open-minded and listen to his staff opinion, either good or bad... I didn't talk to him directly but I can see he listen to us...we are more active and trying to improve our English. I feel good in that we have been support so we have extra energy to work (Opt F n).

One response obtained suggested that one of the reasons that operational staff members tended to be enthusiastic was that they did not seem to have high expectations for their manager to exhibit the equality behavioural characteristic, especially in regards to listening to their opinions, as pointed out by an operational from the back office:

Management people tend to see things better than us. They have skills and experience so that they know things better than us. But sometimes they will ask us what do we think about [a certain] issue. We just tell them what we think. It's great to know that they want to know what we think. But quite often they do thing the other way but I don't feel that they did not listen to us. I know that they are hired to make ideas and decision so I think what they do is the best way to do...(Opt B k).

Another operational staff member from the front office commented that although she saw managers as more open to listening to her ideas than in the past, it would take time to welcome and listen to subordinates' ideas. Nevertheless, this respondent seemed to be satisfied with the level of openness that her manager allowed:

[Did your manager listen to your ideas?] Yes, and sometimes my boss takes my point of view so I feel that I do a good thing to tell her and I have more confidence in telling her and that I do the right thing by telling her. However, you need to understand that sometime things cannot suddenly change according to what we want it to be but it takes time, slowly change...my boss encourage me to keep doing this and I feel great that I can be of any help to her...Sometimes people don't want to tell the not-so-good stuff, especially when they are new, junior or, still in the probation period. But for me, when I have ideas that can solve problems, I usually have a say. Problems means that

we can solve them. So why shouldn't I tell?...I'm so lucky to be under her supervision. She always listens to my views. Some managers are not like this...(Opt F 1).

While both empathy and equality behavioural characteristic of managers was seen to create enthusiasm among subordinates, there was a difference between these characteristics. Subordinates seemed to expect to have some sympathy from their managers. If they did not see some sympathetic act, even in a non-verbal form like smiles, they tended to form a negative feeling towards the particular person. However, subordinates tended to be more willing to compromise and be tolerant if managers did not take up their ideas. But when they knew that managers listened to their ideas, they often reported feeling grateful yet humble.

6.2.2. Negative Emotional Experiences

The findings of this section were centred on two key behavioural characteristics that reflected Gibb's defensive communication climate: "control" and "superiority". According to Gibb's description, the "control" behavioural characteristic was related to defensive communication in those managers who "...secretly view the listener as ignorant, unable to make [his/her] own decisions, uninformed, immature, unwise..." (p. 144), and the "superiority" behavioural characteristic was related to defensive communication in that a manager "...does not desire feedback, does not require help, and/or that [action] likely to try to reduce the power, the status, or the worth of the receiver" (p. 147). However, the finding of this study suggested that the defensive communication climate was created not only by managers, but also by subordinates.

Unlike the responses obtained on the positive emotional experiences which were mostly obtained from subordinates who made comments on their managers, those obtained regarding negative emotional experiences came from both managers and subordinates. Most of the responses suggested that negative emotional experiences often derived primarily from the influence of Thai behavioural characteristics, and some other behavioural characteristics driven by both hierarchical working status and professional values. Thus, the key finding of this section supported the previous literature that the cultural values that existed within organisations had a major impact on the implementation of TQM (Ambroz, 2004; Pool, 2000; Sigler & Pearson, 2000).

More importantly, the findings also suggested that in reality, the managers' expression of their characteristics was far more complicated than one could comprehend by relying on a single, pre-specified framework such as Gibb's. This was because the behavioural characteristics that contributed to the creation of a defensive communication climate derived from not only the managers, but also the subordinates whose behaviour was found to encourage managers to demonstrate more of their seniority and control characteristics.

While there were several examples or situations that reflected the key findings addressed in the above paragraph, this section uses the issues related to the implementation of TQM as a departure point, to illustrate the complexity of Thai cultural values that underpinned managers' behavioural characteristics of control and superiority. Based on the responses obtained, it was found that managers often shared a similar communication problem in regard to the implementation of the quality circle: Plan, Do, Check, Act (PDCA). One manager raised a problem for the "Plan" process because, according to her:

...When we have to do the planning process, we need upward information. We cannot have a realistic and effective plan without inputs from the operational level. But this process usually takes a very long time if we are to have a full discussion forum with the operational staff members...There are so many reasons that they don't want to participate in the discussion and throw in ideas. Some members find it's hard to talk in front of management people. Some members are not shy to talk or express ideas, but they don't want to take on more responsibility. When you do the quality improvement activities, there are always problems or issues to be improved...We can do TQM better than other hospitals because we have our own TQM division to handle all the quality improvement activities, while in some hospitals their staff members have to do the quality work on top of their daily routines...Even though [we have the TQM division], it would be ideal to have everyone involve and share ideas, I hope for the more active side of our staff members...(Mng B w).

When questioning this manager as to how she obtained bottom-up information for the quality planning stage, she replied that:

We discuss with our managers, our quality committee members, and multidisciplinary team who gather feedback from people at their level as well as people under their supervision. Nevertheless, we are able to get data and problems from the bottom line through our quality system. That's why I see it's really important to have a system especially when you want to always need to monitor problems at the bottom line. It's really fast and efficient to gather bottom-line information and at the hospital-wide level...It helps us having valuable information for the planning process (Mng B w).

While the manager above commented on the difficulty in having operational staff members sharing ideas on quality improvement, she had to reply more on the bottom-up information obtained through the hospital's feedback gathering mechanisms for the "Plan" stage. Another Thai manager saw the "Act" stage as the most difficult part, as he explained:

We always have a problem when implementing the PDCA quality circle. It is very difficult to complete communication within this circle. We have no problem in the Plan, Do, and Check stages because it often occurs within a group of people who are responsible for the task. But when it comes to the Act stage, which often needs to be implemented at the hospital-wide level, we have a problem because no one wants to confront others when they encountered problems in the action stage. They feel why do they have to make people hate them. It won't make them look good, when they make a direct complaint to their colleagues. So why bother discussing problems. This problem also happened in hospitals that I worked back in the States. People did not want to confront, if not necessary. But Thais tend to have this attitude to a higher degree. [How do you deal with this problem?] The management has to go in and get involved. Usually in the Act stage, it will be top-down communication. The message must send from authority, in order to make the staff members act (Mng B c).

Two of the key responses above suggested that non-assertive behaviours such as avoiding direct communication, shyness, and avoiding confrontation with Thai subordinates were major barriers in implementing TQM. As for the communication problem outside the TQM reality, this non-assertiveness of Thai subordinates was also raised by other managers. One foreign manager insisted this non-assertive behaviour was found in other organisations he worked with in Thailand. Despite his being well aware of, and understanding this Thai characteristic, it was still the main cause of communication breakdown, apart from the language barrier, as he commented:

Between Thai and foreigners there is a certain different way of communication. Europeans are very straightforward in communication, they prefer to have a one to one communication. But Thais prefer to have a third party to be involved in a communication. So sometimes it's difficult to have a one on one communication. Subordinate staff sometimes will have difficulties to come to see me directly. It's a cultural difference. They prefer to hand the message to the third party who can be my secretary, to tell me. So even if I give them opportunity to talk direct to me, they are not willing to do so. They won't take it because they think their English ability is not good or sometimes, even if they can speak English, they don't feel like interrupting me in my office, they feel uncomfortable to do so. So they rather leave a message with my assistant to pass onto me. They feel it's much easier and more accessible to leave a message to me that way. This happens not just in our hospital but also in my former hotel [an international hotel in Bangkok] I worked with. So that creates

a problem because they prefer to communicate indirectly with me even though there is no barrier like working titles between us. This is a good example of communication breakdown in organisations, and on a cultural level (Mng F e).

While this foreign manager saw indirect communication as a part of the Thai culture that created problems in communication, a comment made by one Thai manager added another aspect of the “more receptive, less active” factor into the non-assertiveness characteristic of the Thai operational staff members who worked at the hospital:

Thai culture is to listen but not do, unless the issue is made as a policy or rule, or an authority tells them to do so. They [Thai subordinates] are very receptive, smile, say yes, and seem to be cooperative. But we cannot take it to mean that they understood our messages. And, if they have some doubts, they will not come back to us. Rather, they will go to their colleagues or supervisors...they are very indirect. Only those who are used to work with western management have direct communication. Usually when having meetings, ideas and comments flow outside the meeting, instead of sending directly in the meeting. Only meetings at the management level, or meetings that are structured produce good outcomes. Otherwise, it is useless to have meetings; it's better off to have an informal discussion one-one-one. Actually this is what people usually do outside the meeting room. No one wants to say things in meetings. They want to do it privately or within a group of people they feel comfortable to let their thoughts out...But the good thing of Thai culture is that they tend to do what they are told, no objection (Mng F b1).

This comment, along with other previous comments, provides more understanding of why managers at the hospital had to use their authority or relied on system controls to ensure communication throughout the hospital, especially information that was sent to and from operational staff members. However, this non-assertiveness of Thai subordinates was also found to encourage their managers to use more of their superior status, as stated in the last sentence of the quote above that, “But the good thing of Thai culture is that they tend to do what they are told, no objection” (Mng F b1).

Several of the responses obtained from Thai subordinates suggested that they were used to following orders from managers. For instance, one from the front-line said that she was pleased if her supervisors took time for an explanation of the issues in the meeting. However, if the manager did not do so it was not something unexpected:

...[in the meeting] managers try to get us to understand the whole situation and explain the reason why problems happened or why we have to do certain things. But there are some issues that they just tell us this is what you have to do without any explanation. [Did you have a chance to ask?] It depends on the

situation. If we ran out of time then it is not possible to ask. If I really want to know I can talk to my manager during the free time. But most of the time, it's not really matter to ask. It should be a good thing so they asked us to do it. And even if it isn't a good thing, I think we still need to do it anyway (Opt F I).

Some subordinates tended to perceive that the role of managers was to make decisions, provide directions, and handle problems or difficulties for them. Thus, the act of control or, seniority of managers can be interpreted as the act of caring and protecting, as:

...When we have a lot of comments, complaints, the management people will take care of it, and we just follow what they say. This is also the same with problems that we face; they will help us solving them. All we need to do is to follow their solution and to ensure they we do it properly and effectively. So I feel they are very supportive (Opt F n).

One manager observed that Thai subordinates' behavioural characteristic reflected a Thai proverb of "following the senior and you won't be bitten by a dog" (Mng B w). This proverb seemed to illustrate well the finding obtained in this study which showed that several respondents were willing to obey to their managers' directions because they felt protected by the seniors. Nevertheless, it was found that communication was seen to play a mediating role behind the subordinates' interpretation of managers' superiority in action—whether it should be perceived as a positive or a negative emotional experience. The first example was obtained from a respondent whose friend, a former employee, had a negative experience from an order made by a manager regarding the employee's resignation, as a respondent who worked at the operational level shared her story:

I think the bosses tend to see things from a different angle which is different from the employee and they don't communicate with each other. So both parties keep thinking in their own way. For example, one employee wanted to quit a job and she wanted to quit soon after she told her boss. However, her boss asked her to work until the end of the month to make it 30 days. So that this employee would not have a bad record if she wants to come back and re-apply for a job. In this way, it will be easier for her to come back, considering that she used to work with our hospital. This was the issue that the boss concerned. However, the employee thought that the boss didn't treat her well, or wanted to make revenge by asking her to stay longer. The problem was that she didn't want to tell the boss that she already had a new job and needed to start working immediately. At the end, this employee just left without completing her 30 days because it was impossible to have two full-time jobs. It was not a good farewell. Both the boss and employee were upset at time this incident occurred. However, later they met and sorted out their differences. It was sad that it took awhile to rebuild the relationship especially when the employee did not quit the job because she didn't like the boss or the boss didn't

like her. But somehow the situation made it look like they didn't like each other (Opt F n).

This response suggests that the respondent who told the story still saw a sympathetic attitude underlying the act of seniority of a manager who made an order to her friend to complete the 30 day period before leaving the hospital. However, the order caused a negative emotional experience from poor communication—that the manager and subordinate did not communicate with each other well. However, the following example obtained from another operational staff member suggests that while poor communication occurred primarily from managers' superiority behavioural characteristic, the respondent saw a negative emotional experience as deriving from the fact that managers did not want to share information with subordinates. As one front-line staff member commented:

I see the morning brief as the place where our voice can be heard. Before, we didn't have this. Before, we communicated issues to managers and they just kept it to themselves, while we wanted them to talk to people at the higher level who had authority. Things get better these day but we still have a similar problem now and then. I think this is a personal vision of some bosses who teach their subordinates not to think too much, or think of other things that are not part of their daily job. They [managers] will try to think of what is good for us and all we have to do is to follow their suggestions and we all will doing fine (Opt F t).

Nevertheless, the responses on negative emotional experience obtained from the hospital seemed to reflect more of the second case when poor communication occurred primarily from a managers' "superior" behavioural characteristic. For instance, one operational staff member talked about her frustration when she had no feedback from her manager:

...my boss seems OK when I ask her to report a certain issue to the management. But I have no idea whether she will deliver my message upward or not. I have no clues whether my boss has already brought my issue up, but the management decided not to take action, or what? So it's like a guessing game, you know...If we could have a response back then it's great. But if not, I just have to wait with my doubt, uncertainty, and of course, not happy. [So you would be happy, simply just knowing that your boss did the delivery] Of course, but again, it's not just one issue. Even if they told me, hey we got your message but they didn't do anything about it. They should at least explain the reason why they didn't want to do anything about it. I can accept that, if the reason is reasonable. But as we are working at the operation level, in the front-line, we tend to see problems more than the management. So if they give me a not so reasonable reason, I would immediately feel it's not right (Opt F pn).

Another provided two contradictory views on communication and superiority. He began his comment by pointing out the advantage of action by a superior when it was used in the top-down communication context. This was because it created smooth cooperation among staff members:

...when we have communication at the horizontal level, especially between work units, it tended to be a problem or disagreement on the responsibility issues such as who doing what and why someone has to do this. But when the message comes from the top, everyone has a clear idea of their responsibility and no need to discuss why, just do it. So I prefer to have management involved because things could be done smoothly this way (Opt B s).

However, when communication and superiority was used in the bottom-up communication context it created negative emotional experiences. The same respondent gave an example from his experience of being a representative of operational staff members in the hospital's staff member of Health and Welfare Committee. He said he was frustrated because he did not know if the issues that he raised reached the top management level:

...We have been trying to communicate upward such as our issue on transportation, but so far we still haven't heard about it. So I think our message may be blocked somewhere along the upward line. I think this issue is related to a budget limitation, so I just want the management to keep us informed about the progress or why the improvement it not yet happening. I'm afraid our message has not been through the CEO. May be when it arrived at the A team [senior management team] and they thought that it was not possible because of the budget constraint and so they put our issue away. I think they should inform us even they say No to us. So we don't have to keep hoping and hoping. It's frustrating. All we want is that, if in the future, if they having budget, they will give priority to our transportation request...I see the hospital rent a car park at the hotel nearby for staff members who have a car and it costs a lot you know. So I think the management should also consider arranging more buses for those employees who do not have a car too...I think the CEO didn't receive our message (Opt B s).

When the researcher received a chance to interview a senior manager who was involved with the employee welfare program, the bottom-up communication problem above was raised this to this senior manager for clarification. This manager commented that:

[I heard that some employees said they felt the issue that they raised at the staff health and welfare committee did not reach the CEO. What do you think about this issue concerned?]....It's quite complicated on issues like this. I mean it can be any thing from managers who didn't handle the issue well, or they don't think it's an important issue to let the top management know. In some cases,

the top management as well as the CEO knows. But some issues are very sensitive and they are needed to be handled very carefully. If not, it could create conflicts between each party. There is always the case of someone gaining and the other losing. It's really difficult to make everyone happy...(Mng B k).

Besides the issue of sensitivity and conflict avoidance pointed out above by one senior manager, there were other reasons that contributed to the absence of feedback from management. One manager provided insightful information that job promotion based on "seniority" was still a common practice at the hospital. This practice was found to create problems in communication because some managers were promoted more for their seniority and less for their management capability. According to this manager, he saw that the problem increased when these managers had to work in the increasingly busy working environment of the hospital studied:

[Why some respondents suspected that their top-down or bottom-up communication message was lost in the middle?] Although our hospital has transformed to a quality managed hospital, the problem is that many current managers are those who grew up with the organisation and got promoted for being a senior. This group of managers is used to a traditional management style. Our working environment has been changing in so many ways. We are busier than before, given our customer volume grow dramatically during the past few years. These managers, including me, got caught up with this busy working environment. We not only have to deal with our daily operations but are also required to solve problems on a timely basis. This is very hard for some managers who saw they have more work but little time. Some managers did not manage their time well. They cannot prioritise their tasks (Mng B t).

Given that this manager raised the issue of the relationship between seniority promotion and time management as a main cause for the loss of communication messages in the middle line of command, he was asked to explain more on the issue.

He commented:

I think managers, especially for those in the healthcare area still stick to the old way of working within a small team and the old style of face-to-face communication. They still feel that they need to communicate to their staff face-to-face...But the dilemma is that both their staff members and themselves is busier than before, and so finding time to communicate is difficult. Some managers just keep hoping that they could find a chance to talk later on but most of the time, it was too late. I think they need to learn to find new way of communication. It may not as effective as face-to-face but it still could get their messages across...We will never have time, if we not manage it well, especially when we do the quality improvement. Our customers have high expectations and managers need to face and solve more problems. So what is best for them is to have a time management skill (Mng B t).

The above comments on seniority promotion, time management and communication skill may provide a better understanding of why some subordinates did not receive responses or feedback regarding the message they sent upward, apart from managers' superior behavioural characteristics. There was one response obtained from a subordinate whose negative emotional experience she described about a top-down communication problem was likely to reflect the above response on the seniority-based-promotion managers, who preferred face-to-face communication and seemed not to communicate well. According to a comment made by this subordinate staff member:

I don't know what communication channels management people use, I don't know whether they have a written meeting memo or not. But when the message comes to us, it is verbally made. I think when the message arrived at our level there is about 60-70% left. I have no idea where, or at what stage that the message started to lose. I don't know how the management communicated with my previous boss so that the message received is complete. [As a result] we did jobs that did not comply with the goal, objective and we had to re-do it. So our job was delayed and we got complaints from both our boss and other people. [Did you bring this issue to people at a higher level?] Not having a chance or not receiving a chance. When it happened, it happened, you know. Just forget and let go. I couldn't do much about it. But sometimes when I really had enough, I would go to discuss with my divisional director about the problem and how can we solve it (Opt B j).

This response seems to suggest the negative emotional communication experience that this respondent derived not only from her manager who did not handle communication well but also from her "just-forget-and-let-go" comment that she made in her response above. This comment in fact was found in the literature on Thais' attitude and behaviour of "forgive and forget" which suggests that Thais tended to have a high tolerance and to avoid unnecessary confrontation.

However, this submissive characteristic was found to allow managers to use more of their superiority and control behavioural characteristic. This was especially observed with some foreign managers who, on one hand seemed to show their sympathy and be willing to compromise on cultural difference. However, on the other hand, it seemed that their socialisation with Thai staff members may encourage them to show more of their superiority. Two of the responses below were obtained from two managers who had been working in Thailand for 8 years and 20 years, respectively. The responses

obtained from these two managers showed that the longer time they stayed in Thailand, the more it was likely that they expressed a superior attitude.

The real advantage of our foreign executive management is that we understand this [issue] and they are really quite adept at communicating with the Thai staff members and trying to make them feel that they are a part of the process. We never look as if we are good and they are bad. But this is the way that they communicate and understand. For us, to be able to communicate with them, we have to communicate in the way that they can understand. [Do you have any problem regarding communication and coordination with other departments in implementing your work projects?] No. I'm in here quite a long time and they get a message that I'm responsible for [a department]...So normally I will discuss what I'm doing in a big picture; just inform everyone that is involved in the implementation when my project is about to start...(Mng B r).

[As a foreign staff member, do you find it is difficult to communicate or to work with many Thai staff members?] Not really. By having a doctor as [a head of one of the frontline division], when I talk I talk with my long experience in Thailand, as a doctor. That's why my ID card printed Dr. [name] instead of [name without Dr. title]. I speak with the power as a doctor and a power of the [management official] so I got the power with a position and a power of being a doctor they are expected to be nice and culturally aware. So that helps...What the hospital did is by bringing me in and put me in [a management position]. In theory I am above doctors. However, I also work with doctors. Besides, I am a doctor so I can be a colleague. I also have a long experience in Thailand so I know how to talk to be nice on what is happening at the Thai cultural level (Mng F p).

Thus, the negative emotional experiences observed in the hospital were found to be created by managers and co-created by subordinates through their Thai acculturation. The findings suggest that the socialisation between managers, whose working position provided them the legitimacy to use their authority, and operational staff members, who tended to possess non-assertiveness characteristics, had resulted in the development of a situation where subordinates were submissive to domination by senior staff members.

6.3. Discussion and Conclusion

The effect of TQM on emotional experiences and coordination outcomes from the findings obtained from this social interaction perspective suggested that achieving coordination in this manner is far more complicated and dynamic than the previously emerging patterns. The hospital management still played a pivotal role in constructing a contextual environment that nurtured shared emotional experiences at the hospital-

wide level through the “quality” status social legitimacy. However, it was found that, at the dyadic level of superior-subordinate interaction, the values of the non-TQM realities such as national values, professional values and personal characteristics and behaviour had an influence on the institutionalised values driven by TQM reality. The findings of this chapter thus suggest that the value dynamics of non-TQM realities posed difficulties for the constructed TQM reality, specifically in the case of maintaining its “international quality standard” social legitimacy status.

The notion of social legitimacy and institutional theory was found to be particularly useful to understand the coordination patterns that emerged in this chapter. This is because institutional theory suggests TQM serves as “a belief system that provides frameworks for common meaning and gives structure and coherence to social behaviour” (Cole & Scott, 1999, p. xviii). This idea is attractive for studies on coordination because it suggests a pattern of social order or coordinated action (Couch, 1992). In fact, this form of coordinated action reflects the coordination of patterns identified in the previous chapters. However, when considered from the social interaction perspective used in this chapter, relying only on the use of a set of belief systems (Cole & Scott, 1999) as a coordination mechanism can be problematic, given that the values from non-TQM realities were found to influence the way staff members at the hospital interacted socially and constructed their contextual condition. Nevertheless, the notion of social legitimacy was still found to make a contribution to understanding coordination outcomes at the hospital. This outcome, however, was found to be achieved in an opposite direction to what has often been emphasised in the notion of social legitimacy from institutional theory which indicates that organisations are pressured to conform to specific social and cultural conventions in their environment in order to gain social legitimacy (Meyer & Rowan, 1977; DiMaggio & Powell, 1991).

Some existing literature on TQM which took this institutional perspective suggests that the value of TQM lies in its symbolic value that supplants its technical (efficiency) value (DiMaggio & Powell, 1983) and thus TQM serves as a ceremonial adoption of organisational practices for legitimacy purposes (DiMaggio & Powell, 1991). Results from empirical studies also support this view. For instance, a survey

conducted among 2,700 U.S. hospitals found that using TQM may provide an organisation with little technical benefit but the claim to use TQM confers legitimacy on the organisation (Westphal, Gulati, & Shortell, 1997).

However, at the hospital, the decision to adopt TQM was not derived from conformity pressures as the existing literature above suggests. Rather, TQM was adopted for its technical benefits to improve internal quality operation during Thailand's economic crisis. In other words, the hospital studied adopted TQM for its technical value. For this reason, several responses obtained commented on the benefit from having an organised and reliable operational system. Given the conditions under which the hospital studied adopted TQM, the contribution of social legitimacy on coordination was found to occur in the later stage. That is, after the hospital had successfully implemented TQM.

In other words, it was found that the hospital experienced a reversed pattern of normative pressure from social legitimacy. The hospital was pressured to maintain its technical legitimacy of an international quality standard, which received ongoing review and re-accreditation from external bodies such as the Joint Commission on Accreditation of Health Care Organisation (JCAHO). Thus, the emotional experiences that were created in this contextual condition can be seen as a form of "coercive isomorphism" in order to maintain the hospital's social legitimacy status (DiMaggio & Powell, 1983). This pressure was found in some responses which were made on the pressure to "live up to customers' expectations". The situation that the hospital faced is similar to Zucker's comment (1977) which provides a divergent view on the institutional perspective in that the motivation for an organisation to adopt a particular organisational structure (such as TQM) or shifts from internal, efficiency concerns to external, legitimacy concerns changes over time as the structure becomes institutionalised.

In addition, institutional theory (DiMaggio & Powell, 1991; Meyer & Rowan, 1977) was also found to be particularly useful for studying the patterns of coordination at a collective level in the hospital. This is because it provides an understanding that interests are socially constructed and embedded in cultural institutions and in

structures of social relations where management and operational staff members share a common understanding of what they are doing. In this way, TQM can be seen to create a collectively constructed social pattern which allowed staff members at the hospital to meet cultural expectations about the production (Berger & Luckman, 1966; Weick, 1995) by creating customer satisfaction and meeting customer expectations through providing services that met the quality standard.

However, the findings of this chapter suggest that, in order to have a better understanding of the coordination pattern from the social interaction perspective, relying on institutional theory alone is not adequate. This is because institutional theory sees that the institutional environment exists “out there” and is portrayed as an objective reality that constrains organisational activity through normative demands (Karnoe, 1997). This view only focuses on an organisational belief system, not the individuals' belief system which was found to have a strong influence on social interaction of the hospital's staff, despite the fact that they interacted within the institutionalised environmental context influenced by TQM. The notion of the individuals' belief system as influencing social interaction and construction is advocated by Weick (1995). Weick saw that individuals perceive different meanings for cultures, norms, and ideologies that are imperfectly transmitted during ongoing socialisation, and thus he coined the notion of “enactment”. Enactment is the process whereby the environment is actively constructed, existing within the constructions of organisational members rather than outside the organisation in the form of an external constraint (Weick, 1995).

Weick's notion of enactment reflects the finding of this study, specifically for the constructed environmental context at the dyadic level where positive and negative emotional experiences were created through social interaction between staff members. The institutionalised values from TQM reality such as “customer focus” and “problem solving” was found to cause managers to exhibit supportive communication behavioral characteristics, and that the behavioral characteristics of managers which were driven by values from non-TQM realities was found to influence the constructed environmental context that nurtured or impeded emotional experiences for subordinates. At the same time, the behavioral characteristics of subordinates were

also found to influence the management's constructed environmental context as well as shaping managers' behavioral characteristics. Thus, this study suggests that studying coordination from the social interaction perspective is necessary to take into account the reality of multiple interpretations of the environment, and of multiple environments whereby participants create and co-create their environmental context (Smircich & Stubbart, 1985; Weick, 1995).

Therefore, the key finding that emerged from this chapter lies in the adaptability and flexibility in the construction of the environmental context that could nurture positive emotional experiences among staff, and this adaptability seems to be found in the open-minded attitudes and behavior that the management and operational staff brought into their interaction and social construction of TQM reality.

Chapter 7

Conclusion

Key Findings and Presentation of a Practical Theory

The study's key findings from the preceding chapters on the three emerging patterns of coordination suggested that the study's aim of developing a broader and more holistic understanding of coordination through a communication perspective has been fulfilled, and that the identified research opportunity on the equivalency of coordination and communication has been confirmed.

In this concluding chapter, the key findings presented in the preceding chapters are conceptualised and presented as a practical theory to address the study's research question. By way of doing so, this chapter discusses the role of social construction which was unexpectedly found to enhance the contribution of the study, specifically, with regard to the interpretation of data and the development of the study's practical theory. It then discusses key implications of the theoretical, managerial and methodological context that emerged from the practical theory. This chapter will conclude with directions for future studies and noting the limitations of the study.

7.1. The Study's Key findings and Social Construction

This study used a hospital that had successfully implemented TQM as a case study investigating coordination from a communication perspective. The evidence obtained from the study on communication attitudes and practices revealed that despite TQM

consisting of several contributing principles, it was the *leadership* principle that demonstrated the most significant value to coordination outcomes.

In this study, coordination is defined as “the process through which parts and actions are organised in ways that enable goal accomplishment” (Chisholm, 1989; Malone & Crowston, 1994). Based on the findings obtained, the research question, “*in what ways have the effects of TQM on communication attitudes and practices contributed to coordination?*” is thus best addressed through the pivotal role of the hospital’s management whose key practices were found to contribute to the organisation of actions that enabled goal accomplishment.

Three patterns of coordination emerged as a result of management practices in this study. Chapter Four addressed the first key management practice on interpretation and articulation of TQM reality which facilitated a “shared meaning and common purpose” pattern of coordination. Chapter Five addressed the role of management’s construction of a TQM influenced working environment which enabled a “shared understanding” pattern of coordination. Finally, Chapter Six addressed the process of social interaction within the management’s constructed TQM reality which contributed to an “emotional experiences” pattern of coordination.

The role of leadership or management in a TQM implementation is widely addressed in empirical research (Lewis, 2000; Savolainen, 2000), academic (Beer & Nohria, 2000; Young & Wilkinson, 1999) and management (Deming, 1986; James, 1996; Juran, 1991; Oakland, 2004) fields. Thus, the findings of this study appear to be consistent with key issues of management’s role: transformative characteristics (Anderson et al., 1994; Waldman, 1994), commitment (Deming, 1986), allocation and arrangement of resources (Oakland, 2004), articulation of common vision (Fairhurst, 1993), and application to quality tools (Gronstedt, 2000), in regard to TQM and its impact on communication and coordination.

However, what has been found to be the *major contribution* of this study derived from observing, analysing, and presenting the evidence obtained on the management’s practices based on the notion of social construction. From this view, it suggests that the role of management’s communication in TQM implementation and in contributing to coordination appears to be far more complex than has been discussed in the

existing literature. Prior to the discussion of this key issue, the following section considers the role of the philosophy underpinning the data analysis and interpretation, social construction, given to its significance in shaping the key findings obtained in this study.

7.1.1. Significance of the Underpinning Philosophy: Social Construction

The key findings of this study have been advanced through the notion of social construction. This thesis was embarked upon to investigate coordination from a communication perspective, in order to fill an identified research gap. However, it has also turned out to be a discovery journey for the study's underpinning philosophy, social construction, which has shifted the researcher's perspective about interpretation and presentation of the data obtained and therefore, this newly acquired perspective should be considered as another significant finding of her endeavour on the doctoral study as a novice researcher. This section discusses how the new approach driven by social construction allowed the researcher to fulfil the study's aim and research question.

Although investigating coordination from a communication perspective allowed the researcher to obtain rich data from the hospital studied as well as being able to observe coordination in a variety of forms as presented in the previous chapters, these data were highly complex and made the presentation of the data in a logical order a difficult task—given the effects of each TQM principle on communication were often related one to the other, and that they also showed direct and indirect impacts on communication practices.

However, the influence of the notion of social construction during the data analysis improved the researcher's ability to interpret the data in two main respects. First, social construction emphasises a rich and “coherent interpretation”, which Denzin (1989) described as being “...based on materials that are historical, relational, processual, and interactional” (p. 64). This view encourages the researcher to look for a holistic, adequate picture of the whole phenomenon—that is, although the data obtained on the effect of TQM on communication were highly fragmented, the social construction perspective led the researcher to pay close attention to the hospital's management role.

Salancik and Pfeffer (1978) saw that social construction of reality occurs through the processing of social information in which management needs to construct a social environment that provides “a direct construction of meaning through guides socially acceptable beliefs, attitudes and needs, and acceptable reasons for action” so that this constructed environment made normative and informational cues more salient and provided “expectations concerning individual behaviour and the logical consequences of such behaviour” (p. 227). This view implies that although TQM is a strategy oriented toward organisation-wide quality improvement, it has no real value unless it is interpreted and is given meaning to suit a particular purpose and context in which TQM is adopted. The role of management thus emerges as the key factor behind “shifting organizational members out of their ordinary interpretations of everyday reality” (Berger & Luckmann, 1966, p. 24) into the new reality influenced by TQM.

As for the second aspect, social construction emphasises the active role of participants as ‘social actors’ (Berger & Luckmann, 1966), regardless of their working position, who interact and construct a shared meaning and reality through communication. This view encouraged the researcher to be more reflexive when analysing the responses obtained and thus allowed her to develop a further understanding beyond the study’s initial aim of investigating communicative attitudes and practices within the TQM context, to also observe how the interaction within and between management or operational staff members enabled or constrained their communication and interaction.

The data analysis based on this approach has an important implication, regarding the role of management in communication. Several accounts made by TQM writers (e.g., Beer, 2003; Oakland, 2004) often referred to a transmission theoretical model of Shannon and Weaver’s (1949) sender-message-receiver-feedback-interference when discussing the role of senior managers’ communication in TQM implementation. This view treats senior managers’ communication activities as unilateral communicative actions and assumes the powerful role of the managers in stabilising the organisation by communicating vision and educating employees about the benefits of TQM implementation.

Putnam (1999) also observed that much of the published research in the management and business field often referred to the transmission theoretical model of Shannon and Weaver's (1949) sender-message-receiver-feedback-interference with researchers studying a linear process of communication. This approach is also found in Lewis's empirical work that examined communication during TQM implementation (Lewis, 1999, 2000) which documented the detailed investigation of the communication process utilising Shannon and Weaver's (1946) model.

This researcher has no intention of denying the usefulness of the transmission model in investigating the effect of TQM on communication, given that the amount of communication flow is one of the key criteria for effective communication within organisations. Nevertheless, the transmission view of communication undermines the fact that employees are social actors who not only actively construct and reconstruct meaning, including those sent from senior managers, but also influence on the way managers communicate and interact with them. Integrating the notion of social construction into the transmission view of communication permits a more holistic understanding of the phenomenon studied. The following section provides a summary of the study's key finding that emerged from the social construction perspective.

7.1.2. Social Construction and the Study's Key Findings

Through the lens of social construction, three key patterns of coordination were observed in this study. Apart from the coordination pattern of *shared understanding* that was originally found to be associated only in the management's construction of a TQM influenced working environment (chapter 5), two more patterns of coordination were also found to emerge. The first pattern of *shared meaning and common purpose* derived from management's interpretation and articulation of TQM reality (chapter 4) and the second pattern of *emotional experiences* derived from social interaction processes that occurred within the management's constructed TQM reality (chapter 6). Table 7.1 summarises the key findings on the relationships between key TQM influences, management practices and characteristics of coordination contributing to the emergence of coordination patterns in this study.

Table 7.1: Summary of the Key Findings

Key findings	Key TQM Influences	Key characteristics of coordination
<p>Chapter 4: Management’s interpretation and articulation of TQM reality</p> <p>1. Introducing TQM as a business survival strategy</p> <p>2. Communicating common purpose on improving quality service and on achieving hospital accreditation and re-accreditation (i.e., vision, mission, goals guiding value statements)</p> <p>3. Articulating the collective “customer Focus” reality</p>	<p>- Leadership</p> <p>- Quality improvement</p> <p>- Common goal</p> <p>- Customer focus</p>	<p>“Shared meaning and common purpose”</p> <p>Legitimacy for top-down TQM implementation</p> <p>Shared direction and expectation</p> <p>Customers as “social bond” and “social motivation”</p>
<p>Chapter 5: Management’s construction of a TQM influenced working environment</p> <p>Key management arrangements:</p> <p>1. strategic business planning process</p> <p>2. training</p> <p>3. TQM division & standardised working processes</p> <p>4. meetings</p>	<p>- Leadership</p> <p>-Process focus</p> <p>-Continuous improvement</p> <p>-Teamwork</p> <p>-Problem solving</p>	<p>“Shared understanding” through the increase of:</p> <p>1. Spontaneous, multidirectional communication flow</p> <p>2. Clarity and consistency of information and communication</p> <p>3. Realisation of interdependent working relationship nature</p>
<p>Chapter 6: Social interaction within the management’s constructed TQM reality</p> <p>Two levels of social interaction within management’s constructed TQM reality:</p> <p>1. Institutional level: Manager-subordinate interaction and communication within the quality reality and internationalism working values</p> <p>2. Dyadic level: manager-subordinate interaction and communication influenced by TQM as well as individuals’ belief systems (e.g., organisational value, Thai- influenced values, professional values, personal traits and characteristics)</p>	<p>- International quality standard</p> <p>- Leadership</p> <p>- Customer focus</p> <p>- Problem solving</p>	<p>“Emotional experiences”</p> <p>Positive and negative emotional experiences obtained through social interaction serve as a determinant factor in the level of energy to be invested in coordination</p> <p>1. Institutional level: a sense of social legitimacy status from achieving “international quality standard” through TQM implementation</p> <p>2. Dyadic level: emotional experiences influenced by communication behavioural characteristics involved in the interaction between manager-subordinate</p>

Apart from the leadership principle of TQM that demonstrated its most influence through the role of management, there are some other TQM influences that have their

effect on management's practices, contributing to various characteristics that formed the emergence of coordination pattern in each chapter.

The emerging of the coordination pattern of **shared meaning and common purpose** in Chapter Four was the result of the interaction between the management's interpretation and articulation, and the three key TQM influences of quality improvement, a common goal and customer focus. *Shared meaning* derived from the management's ability to interpret TQM's "quality improvement" and "customer focus" that fit the hospital's environmental context. The fit in management interpretation was found to have a positive impact on coordination as it increased the hospital's staff members' receptivity and encouraged them to engage in shared meaning at the hospital-wide level.

In the study, the first "fit" was found on the interpretation of TQM as a business survival strategy. Instead of downsizing the business during the economic crisis, the management's decision to focus on internal quality improvement by adopting TQM allowed them to gain legitimacy and cooperation from staff members toward TQM implementation despite the use of a top-down approach. The second "fit" was found on the management's interpretation and articulation of TQM from a customer focus perspective which was congruent with the hospital's existing "customer focus" values. This made "customers" a reason for acquiring and maintaining coordination among staff members. "Customers" thus served as a social bond and social motivation that facilitated coordination at the hospital studied.

As for the *shared common purpose*, it derived from the interaction between TQM's "common goal" and the management's communication practice. The notion of TQM's common goal made the management aware of the need to ensure that the goal of quality improvement including improving quality service and achieving hospital's accreditation was consistently communicated, either implicitly or explicitly, through various channels. This management practice served to remind and reinforce staff members of the shared direction and expectation that the hospital aimed to achieve.

In Chapter Five, the **shared understanding** pattern of coordination derived from the interaction between TQM influences and the role of management in constructing a

working context that was supportive of TQM. In this study, the shared understanding was seen to facilitate coordination because it reduced conflicts, misunderstanding, or misinterpretation between staff members thus enabling them to work successfully together. There are two key characteristics contributing to the shared understanding pattern that emerged from the interaction: the flow of communication and the realisation of the interdependent working nature. The influence of TQM's "process focus" and "continuous improvement" was found on the management arrangement of strategic business planning process, training, and TQM division and standardised working process. The increase of the quality and quantity of communication flowing through these management arrangements reduced the gap of knowledge and thus increased shared understanding among staff members. As for TQM's teamwork and problem solving, it was found that the notion of these two influences on the management's arrangement of meetings created and nurtured a sense of togetherness. Responses obtained from interviewees from both the management and operation level suggested their appreciation of this interdependent working relationship.

Chapter Six presented a coordination pattern of **emotional experiences** which emerged from the social interaction process within the management's constructed TQM reality. This pattern of coordination demonstrated the most dynamic pattern of coordination observed in this study. The data obtained suggested that the social interaction process resulted in the creation of positive or negative emotional experiences that affected the extent of energy that respondents invested in achieving common goals. In the study, the emotional experiences were observed to be derived from the respondents' social interaction within two particular management constructed TQM influenced working contexts: (1) an institutional level and (2) a dyadic (interpersonal) level.

At the institutional level, the emotional experiences were derived from manager-subordinate interaction and communication within the management's constructed social reality. It was found that a sense of social legitimacy deriving from "quality reality" and "internationalism", as a result of passing the international quality standard, created positive emotional experiences that encouraged staff members to invest their energy in coordination. At the dyadic level, the positive or negative emotional experiences were found to derive from communication behavioural

characteristics involved in manager-subordinate interaction. However, besides TQM's customer focus and problem solving, the individuals' belief systems such as national values, professional values and personal characteristics and behaviour were also found to influence the communication behavioural characteristics involved in manager-subordinate interaction and communication. This means that other influences outside the management's constructed TQM reality can be positively or negatively related to emotional experiences and thus to coordination outcomes.

All in all, based on the findings obtained from Chapter Four to Six, it can be observed that the emerging patterns of coordination occurred in two contextual conditions of: (1) shared meaning and understanding as a result of management's interpretation and construction of TQM reality and, (2) shared emotional experiences as a result of social interaction process where staff members brought with them their own realities into their interaction with others, within the constructed TQM reality. It is this latter contextual condition which demonstrates that achieving coordination is complex and thus can be difficult to control by management. However, this finding does not suggest that coordination is impossible. Rather, it suggests that by integrating the influential process of social interaction into the understanding of the nature and characteristics of coordination, coordinated actions can be achieved and maintained.

7.2. Conceptualisation of the Key Findings

For further discussion, this section locates the key findings of the study within the relevant existing literature and theoretical concepts. It begins by arguing that while TQM was found in this study to be equipped with values and tools that are conducive to coordination, the extent to which TQM can facilitate and nurture coordination depends on how TQM is interpreted and constructed by top management. Coordination not only derives from the allocation of resources and management of interdependencies (Malone & Crowston, 1994; Thompson, 1967), but more importantly from the *shared meaning* and *understanding* as a result of management's interpretation and construction of TQM reality—suggesting a strong link between top management's cognition and its influence on coordination outcomes at the organisational-wide level.

To provide a theoretical understanding of the interplay between TQM and top management and its contributing outcome on coordination, the key findings obtained in this study are conceptualised within the cognitive perspective which is found to encompass all the key findings in the study. The organisation of this conceptualisation is based on three key interrelated aspects. The *first* aspect discusses the top management's cognitive processes by pairing top management's interpretation and construction of TQM reality with two cognitive concepts of sensemaking and sensegiving. The *second* aspect discusses the role of "consistency", found in management's sensemaking and sensegiving, as a contributing factor in facilitating the "shared" TQM reality. Finally, in the *third* aspect, it discusses the role of the "shared" TQM reality as the contextual condition for organisation-wide coordination. This study argues that it is this contextual condition that allows top management to be in a better position to manage and maintain coordination, despite the dynamic of social interaction influenced by other existing realities.

7.2.1. Cognitive Perspective: Sensemaking and Sensegiving

Cognitive schemes are an individual interpretation scheme which Ranson, Hinings and Greenwood (1980) saw as the personal and organisational maps that staff members use to help them organise and make sense of their workplace experiences. However, social constructionism aims to understand more the collective process than the individual process of thinking (Chen & Pearce, 1995) which is emphasised by social constructivists (Guba & Lincoln, 1998). For the purpose of this study, the notion of cognition is approached from its basic assumption of shared understandings within organisations that influence organisational behaviour (Daft & Weick, 1984). In what follows, two cognitive concepts of "sensemaking" (Weick, 1995) and "sensegiving" (Gioia & Chittipeddi, 1991) are adopted as a theoretical scaffolding to assist with the conceptualisation.

Sensemaking is a cognitive process that occurs when individuals rely on their previous knowledge and experiences in attempting to understand situations or issues they encounter (Weick, 1979). According to Weick, sensemaking involves not only pure cognitive interpretative processes, but interpretation in conjunction with action. On the other hand, sensegiving (Gioia & Chittipeddi, 1991) reflects "processes in which individuals attempt to give meaning to what they understood in the way that

another party understands or makes sense” (p. 443). Gioia and Chittipeddi (1991) combined the notion of sensemaking and sensegiving and applied them in organisations’ context to describe the simultaneous way in which messages flow in and out of an organisation’s cognitive system.

The concepts of sensemaking and sensegiving mirror the process by which individuals constantly make meaning and give meaning to their social construction of reality, given that Salancik and Pfeffer (1978) observed that the social construction of reality occurs through the processing of social information. Similarly, Smircich and Stubbart’s (1985) notion of enactment implies that organisation exists in a pattern of “on-going action-reaction among social actions” (p.727), which “differentiates organisation from the non-organisation” (p.726). According to them, organisation is defined as “the degree to which a set of people share many beliefs, values, and assumptions that encourage them to make mutually-reinforcing interpretations of their own acts and the acts of others” (p. 727).

Besides reflecting social construction processes, the value of sensemaking and sensegiving to the development of a practical theory for this study lies in its theoretical reflection on the characteristics and patterns of coordination that have emerged in this study. Although everyone in organisations, regardless of their working position, constantly performs sensemaking and sensegiving, this study found that the sensemaking and sensegiving processes at the top management level have the most significant contribution to coordination outcomes. Not only does top management have the authority to distribute power and mobilise resources (Nedler & Tushman, 1997), but the organisation’s interpretation of its vision and mission is seen as the province of the top managers (Daft & Weick, 1984).

The appreciation of the influential role of leadership from the organisation’s cognitive perspective may explain why TQM literature places strong emphasis on the important role of leadership in the success or failure of its implementation (Beer, 2003). However, the current literature tends to pay more attention to the characteristics of leaders contributing to the success or failure of TQM implementation (e.g., Savolainen, 2000; Beer, 2003) and less on the relationship between leaders’ sensemaking and sensegiving processes and TQM implementation. Nevertheless,

there are some studies that emphasise the cognitive processes in TQM implementation, and thus lend a support to the present argument for taking such a cognitive approach.

Ford and Ford (1995) observed the successful communication in organisational change depends, firstly, on the initial interpretation and translation of a particular change strategy. Reger et al., (1994) argued for the need to study TQM from a “cognitive perspective” because TQM requires a paradigm shift about the basic assumption about the organisation. This argument is consistent with ones from Gioia, Thomas, Clark, and Chittipeddi’s (1994) whose empirical study on the investigation of a strategic change process at a public university suggested that the strategic change might usefully be cast as a process of reinstitutionalisation of cognitions, actions, and practices. Gioia et al.’s (1994) emphasis on the interplay between cognition, action and practice is particularly useful for the study of coordination because it reminds us that meaningful and purposeful coordination occurs when *cognition drives actions*. However, to facilitate coordinated action at organisation-wide level requires a cognition that is “shared” at the organisational level and this issue is central to the role of “consistency”, which the discussion now turns to.

7.2.2. Consistency: the Key Contributing Factor to the Shared TQM Reality

The fact that realities are constructed and reconstructed through social interaction (Berger & Luckmann, 1966) implies that if the new reality is not consistently constructed and articulated, it will be reconstructed by other dominant realities. In this study, “consistency” was observed in the top management’s practice of sensemaking and sensegiving of TQM and was seen to play an important role in facilitating the emergence of a “shared” TQM reality—the organisation’s cognitive system that helped the hospital’s staff members to have a common orientation in performing sensemaking and sensegiving in their daily operations and social interaction. Based on the study’s findings, three key aspects of “consistency” were found in top management’s sensemaking and sensegiving of TQM reality.

The first aspect of consistency is found to be related to the *management’s sensemaking on TQM adoption* which matched the situational economic crisis that the hospital faced at time of its adoption and the hospital’s existing customer focus value.

The fact that the top management interpreted the economic downturn of 1997 as a good opportunity to focus on internal quality improvement, and that TQM was interpreted as an extension of the hospital's customer philosophy, allowed management to gain support from the hospital's staff in TQM implementation. TQM was seen as an effort that extended the hospital's current practices and also as a means to increase both quality assurance for customers and market advantage over competitors. This created a sense of shared interest among staff members for both the hospital's survival and its existing customer focus value.

The second aspect of consistency was related to the *management's sensegiving of the "meaning" of TQM reality*. Top management was found to consistently articulate TQM as a way to maintain quality standards for "customer satisfaction" and "hospital accreditation" through various means including the hospital's vision, mission, shared goals and guiding values. This aspect of the management's consistency in sensegiving thus can be seen as a form of rhetorical construction of TQM reality which had its intended effect of cultivating a shared meaning and common purpose, similar to Weick (1995)'s notion that creating purpose is socially constructed because "choice imposes value on information" (p. 159) which engage the audience's emotion about the action advocated.

The rhetorical value of TQM elements such as common goals, a common vision, and customer satisfaction is widely recognised in the existing literature. Several empirical studies observed the positive effect of TQM rhetoric on the alignment of staff members' attitude and behaviour in achieving a common purpose (Fairhurst, 1993; Gioia et al., 1994; Savolainen, 2000; Reger et al., 1994). As for the hospital studied, customer satisfaction and expectation had the most rhetorical value which in turn serves as a legitimate social motivation as well as a coordination mechanism in motivating staff members to put their effort to maintaining the shared common purpose.

The third aspect of the consistency was related to the management's *sensegiving of the "means" to TQM reality*. In this aspect, consistency was observed in a form of communication and information flow and regularised interaction patterns, resulting from the administrative arrangement of means that "match the expectations or

requirements” of TQM (Sitkin, Sutcliffe, & Schroeder, 1994), or means that ”conform to the legitimacy” of TQM (Meyer & Rowan, 1977). While the findings of this study share a similarity to mainstream empirical studies that the arrangement of communication system and processes to support TQM implementation has resulted in the increase of communication and information flow, it was also found that these administrative arrangements also provide intangible values—“shared understanding” and “reciprocal relationships” between staff members which was nurtured through their interaction within arranged coordination mechanisms such as meetings and workshops.

7.2.3. The Shared TQM Reality and Coordination

The fact that this study approaches coordination from the position that coordination is inherently communication activities (McPhee & Zaug, 2000; Ballard & Seibold, 2003), the contribution that the “shared” TQM reality has on organisation-wide coordination is similar to the notion of “common ground” in which meaningful communication is facilitated from mutual knowledge and suppositions (Clark & Brennan, 1991). However, the term “shared reality” is used here to emphasis its role as a contextual condition that encompasses the shared institutional belief system and social structure that underpin communication and social interaction between staff members at the hospital studied. Three patterns of coordination were found to emerge within this contextual condition of shared TQM reality: *meaningful coordination*, *patterned coordination* and *emotional coordination*.

Meaningful coordination was facilitated by the top management’s constructed shared meaning which served both as an impetus and a normative cue for staff members’ sensemaking and sensegiving in their daily communication and social interaction. The shared interest in customers and in achieving and maintaining the social legitimacy of quality status had a positive impact on staff members’ communicative behaviours, specifically in regard to exchanging information in pursuing their common interest—managers were found to be communicative and feedback-seeking whereas subordinates were found to be receptive and cooperative. Achieving coordination in this manner mirrors Weick’s (1995) notion of “heedful relating”. According to Weick, this occurs when staff members pay more attention to what they are doing and act in

ways that demonstrate that they understand how their own job fits with the job of others to accomplish goal of the system.

Patterned coordination was facilitated by top management's arrangement of means and social structure. In terms of coordination, this management practice mirrors the idea of creating a network of relations and dependencies between units or staff members both hierarchically and laterally so that information can be exchanged effectively at the organisation-wide level. The arranged patterns of social interaction thus create the possibility of joint action as well as increased shared understanding between staff members, resulting from the social adjustment processes in which one person adjusts their behaviour in light of the expectation of others in order to fit together in lines of action.

Unlike the previous two patterns where top management can exert their influence directly, the third pattern of coordination emerged from the *emotional experiences* that staff members co-created through their social interaction within the top management's constructed TQM reality. When social interaction is driven by the shared TQM reality, it creates emotional experiences associated with the social legitimacy specifically those deriving international quality standards, and this motivated staff members to invest more of their energy in accomplishing the reality that they shared.

However, people are also influenced by other realities including ones' own belief systems and past experiences, as well as some situational or environmental factors such as the pressure to provide quality services under the time constraints or the change in human resources (e.g., new staff members, change in organisational structure). To some extent, these realities influence staff members' cognition and consequently their communication behaviours, making it difficult for top management to anticipate whether or not the social interaction would produce the type of emotional experiences that enhance or impede the coordinated action necessary to achieve the shared TQM reality. Given this, one of the most efficient and effective ways for top management to maximise their control over the coordination outcome is through their consistency in sensegiving of the shared TQM reality, to make the constructed TQM reality salient in the multiple realities world.

7.3. The Practical Theory and Its Implications

This section begins with the presentation of the practical theory deriving from the conceptualisation of the findings in the previous section. The practical theory is then used as a platform for the discussion on key theoretical and practical implications of the study.

Figure 7.1 presents the practical theory of the effect of TQM on coordination. This illustrates the sequential effect of TQM on coordination: (1) the effect of TQM on the hospital's top management, and (2) the effect of top management's interpretation and construction of TQM reality on the hospital's staff members. However, the emergence of coordination is seen to be facilitated and nurtured as a direct result of the second effect. More importantly, coordination is underpinned by three key factors of "consistency", "shared reality", and "social interaction processes". If these three elements co-exist and reinforce one another, it is likely to produce three patterns of coordination: meaningful coordination, coordinated action and emotional experiences.

However, it should be noted that this practical theory is not meant to be a generic model of the effect of TQM on coordination. Rather, it reflects the localised knowledge obtained from the study. The phrases are described here in the text in linear sequences approximating the primary order undertaken. In reality, the phrases should be understood as a dynamic, cyclical process. More importantly, the practical theory is developed with the aim to demonstrate the effect of TQM on coordination. Thus, this practical theory depicts the moment of best practices and highlights the best possible contextual condition for the emergence of coordination patterns.

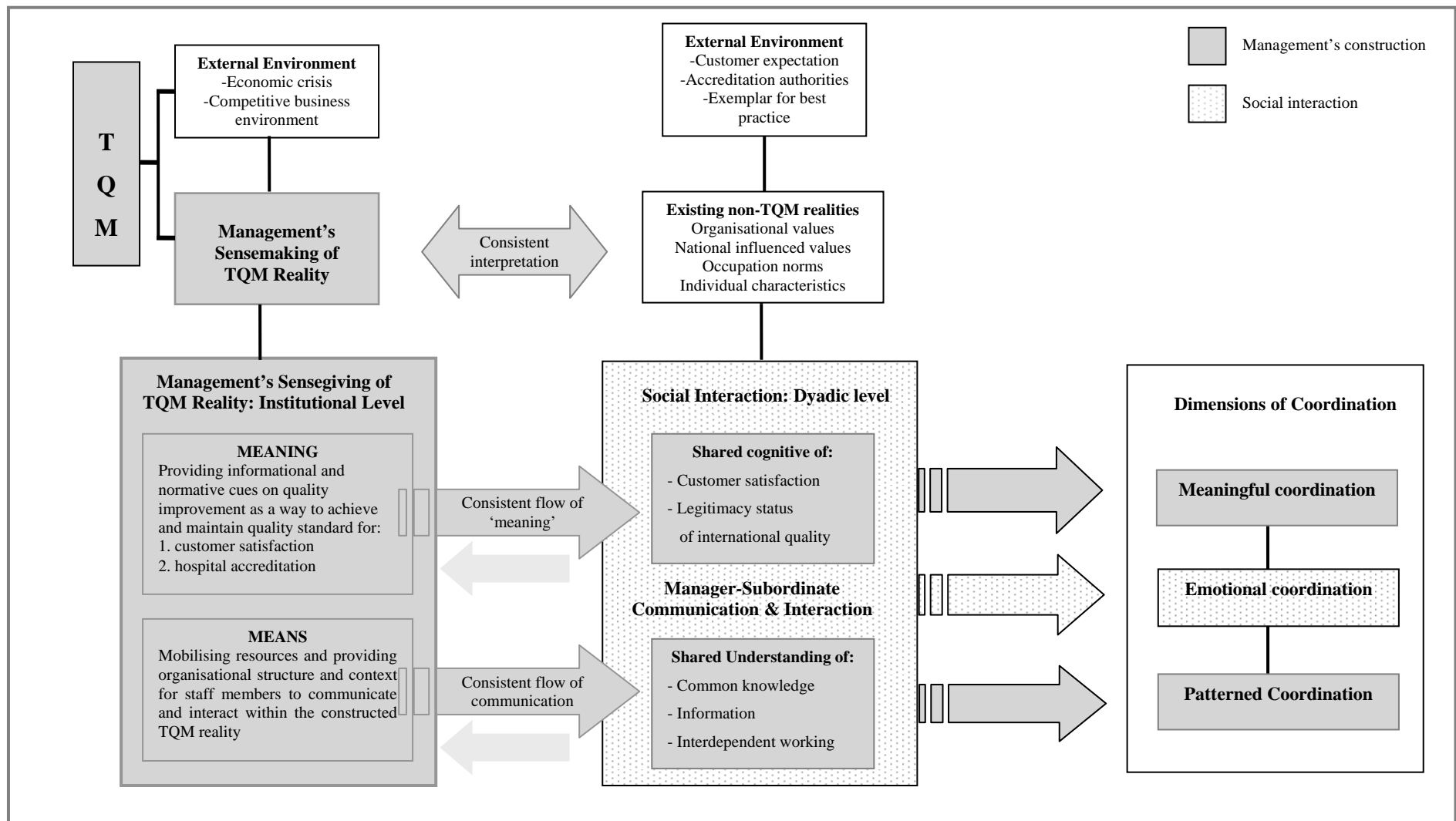


Figure 7.1: A Practical Theory of Management's Social Construction of TQM Reality and Its Coordination Outcomes

7.3.1. Theoretical Implications

This particular practical theory suggests two key implications which derive from the understanding of social construction. The first is on the role of leadership¹⁷ communication in TQM implementation and its contribution to coordination outcomes. The second specifically focuses on the emotional coordination pattern which is found to have most effect on staff members' decision to invest their energy in pursuit of the common goal.

7.3.1.1. Leadership as Management of Shared Reality

In order to achieve coordination in a way that is responsive to the process of social construction within organisations, leadership communication practices should be taken in the realm of management of shared reality. This means that leadership communication involves not only the administrative arrangement element of “means” for communication and interaction but also the cognitive, interpretive and rhetorical element of “meaning”. However, the current TQM literature on leadership communication often addresses the “means” and “meaning” element separately.

Literature that focuses on the role of leadership communication in regard to the “means” elements is centred on TQM processes, tools, and activities that enable staff members to work successfully together (Lemak & Reed, 2000). Many accounts of TQM and communication often focus on the effectiveness and efficiency of the arrangement of organisational structure and system that support communication within the TQM implementation process. The key criterion concerning the role of leadership communication is effectiveness in the arrangement of means and communication satisfaction from factors such as amount of communication flow or timely communication. While the means is found to keep up with the process of social interaction as it is regularised in the pattern of interaction, it can create routine and mindless interaction. More importantly the increase of communication flow is not always a justification for meaningful communication.

¹⁷ Leadership is used in this section instead of top management to be consistent with the TQM literature references which often address the role of top management under “leadership”.

Literature references that focus on “meaning” often are centred on the common vision principle of TQM such as visionary leadership (Fairhurst & Sarr 1996), charismatic leadership (Wendt & Fairhurst, 1994), transformational leaders (Waldman, 1994) and leaders’ uses of framing devices (Fairhurst, 1993). In an extreme view, Smircich and Morgan (1982) argue that leaders are seen to succeed in TQM attempts through their rhetorical skills, because “leadership involves a dependency relationship in which individuals surrender their power to interpret and define reality to others” (p. 258). While the literature on the “meaning” element is significant to the construction of organisation’s cognitive system, it tends to overlook the fact that staff members are active agents who make and give meaning through their social interaction.

There are accounts on leadership communication in TQM that include both “means” and “meaning” elements. However, these tend to assume a unitary effect of leadership communication on organisational outcomes and thus neglect the multiple realities in organisations which can impede leadership communication efforts. By integrating the understanding of the social construction of realities, leadership communication is then seen to be centred on “management of shared reality”—a social context consisting of a set of *meaning* and *means* that guides staff members’ collective thoughts and actions in their daily social interaction. This leadership role also reflects what Alvesson (1996) called “opening-up” of the social reality of an organisation in which organisation members can become more aware of and reflexive about social relations within the organisation.

7.3.1.2. Emotional Coordination as Energy-in-Action

Among the emerging patterns of coordination, the one that emerges from emotional experiences is the most dynamic, yet powerful form of coordination that occurs as a result of social interaction processes. This study sees this form of coordination as a by-product of staff members’ social interaction which when occurring in a “shared reality” context are likely to turn the emotional experiences into a powerful, coordinated energy-in-action. However, this implication may raise the question if “shared reality” is the key to enhancing emotional coordination. This would mean that any concept, other than TQM, that is capable to assist managers in the creation of a shared reality can be conducive for coordination.

This would then raise another question: what makes TQM more valuable than other concepts, in regard to coordination outcomes? Apart from the fact that the analysis of the study suggest a similar observation made by TQM writers (e.g., Dean & Bowen, 1994; Deming, 1986; Hackman & Wageman, 1995) that TQM's comprehensive and reinforcing principles, tools and activities are conducive for coordination, this study argues that it is the approach to social legitimacy that makes TQM distinctive from other concepts. More importantly, the link between the social legitimacy status of TQM and emotional experiences can elevate the energy-in-action.

The social legitimacy status of TQM is acknowledged by academics and practitioners, specifically for its rituals and ceremonies such as quality awards, benchmarks and best practice recognition programs. The hospital studied regularly participates in these activities and being recognised for its quality achievements in both awards and selected best practices. Given this, other concepts may not have the same level of the social legitimacy status and may not generate as much as emotional experiences as TQM. Another interesting issue found in the study regarding the link between social legitimacy and emotional experiences is that it creates a cultural compromise working environment, as staff members tend to minimise their differences to meet their quality standards and customer satisfaction.

7.3.2. Managerial Implications

The value of TQM on the issue of coordination lies in the ability of management in interpreting and constructing both "means" and "meaning" of the TQM reality that is congruent with the existing realities held by the majority of members of the organisation. Therefore, the leadership role "management of shared reality" which has been discussed in the previous section is also considered a key implication for managers. This section thus further discusses two specific issues that are related to the "management of shared reality". The first is the consistency of management's sensegiving activities in regard to the alignment of communication attitudes and behaviours in achieving the common goal. The second issue relates to some possible disadvantages that the "shared reality" may have on communication and coordination.

7.3.2.1. Consistency in Sensegiving

Organisations consist of multiple realities and it is not always possible for management to ensure that the constructed reality is not undermined by other realities. Thus, the key task of management is to consistently provide informational cues in both “means” and “meaning” of the newly constructed reality, to make it clearly defined enough to allow the process of social construction to occur. The significance of consistency in providing both means and meaning is that they provide two sets of organising tools to assist staff members in their sensemaking and sensegiving activities: (1) the shared meaning and (2) shared communication mechanisms. If achieving shared meaning is not possible, staff members (particularly newcomers) can still rely on shared communication mechanisms with others to maintain coordinated action. The value of these sets of shared meaning and means is also found to guide the positive energy emerging from emotional experiences towards achieving the common goal, instead of wasting positive energy in uncoordinated directions.

Management’s consistency in sensegiving also contributes to the establishment of new communication behaviours. As found in the study, some non-assertiveness characteristics such as avoidance of “losing face” or “criticism” which can be an obstacle to team-working (Komin, 1990; Sripuntanakun, 1990) did not appear within the customer-focused context. Staff members especially those from the operational level did not appear to exhibit their shyness or confrontation avoidance when it came to reports or discussions on customer-related issues. But this communicative attitude did not occur on issues related to more personal problems. This study sees that the more assertive communication behaviour was a direct result from the management’s consistency in sending informational and normative cues, formally (customer feedback gathering mechanisms, the set up definite timeframe for customer feedback investigation) and informally (feedback seeking behaviours, use of rewards) that made communication about customer-related issue a legitimate, normative practice in the organisation.

Nevertheless, this study also observed conflicts and communication difficulties that occurred when informational cues were vague and caused staff members to rely on their own interpretation, influenced by ones’ own set of belief systems and defending

ones' own position. A good example from the hospital studied is the scope of the meaning of "customer satisfaction", whether it should be interpreted from the perspective of customer service or from cost of service. The mixed message given by management about "world-class service" on the one hand, and "value for money" on the other, created some confusion and tension among staff members from different departments. This may cause problems when each department relies on their own professional values to assist with its interpretation. For instance, the marketing department interprets customer satisfaction as providing value for money and use this interpretation to attract more customers; whereas the customer service department interprets customer satisfaction as providing the best customer service regardless of the cost and find themselves struggling to live up to their own version of the interpretation.

7.3.2.2. Disadvantages from the Shared Reality

While the idea of constructing a shared reality assists management in organising and facilitating collective thoughts and actions among staff members within an organisation, its drawback needs to be mentioned. The fact that people shared the same reality means that they tend to put a priority on one reality and filter out information related to others. One example that was observed from the hospital studied is the shared focus on customers. Most of the positive feedback on internal communication satisfaction which was provided by staff members, specifically those at the operational level, was found to be related to customer-related issues; whereas those of the negative feedback were often found to be related to work-related issues.

Although the evidence obtained was insufficient to draw a conclusion, it may be possible that when the work-related messages were communicated upward, it was filtered out to give priority to the messages related to customers. Although at the time of the study the evidence of this problem was not yet significant, over time, it could become a major threat to the shared customer reality, if more and more staff members who have similar problems start to share their negative experiences. Therefore, maintaining alignment between the shared reality and other existing realities is another challenging task of the role of leadership in the management of the shared reality.

However, as coordination also emerges from emotional experiences, nurturing another reality to co-exist in parallel with the core reality could help managers to maintain the management of shared reality. This study sees that the notion of “social health” (Farrell & Geist-Martin, 2005), which emphasises the quality of network of professional and personal relationships, has a potential to be promoted as a parallel reality to facilitate interaction and build camaraderie among peers. Besides having a universal appeal, the notion of social health is particularly appropriate for Thai culture where social relationships and interconnectedness are highly valued in the workplace (Komin, 1990).

7.3.3. Methodological Implications and Direction for Future Studies

Consistent with the key implications discussed in the previous sections, the methodological implications and direction for future studies are centred on the leadership role in the management of reality.

7.3.3.1. Leadership, Organisational Context and Coordination

Studies on TQM and coordination often focus on the link between the leadership type such as visionary, charismatic and transformational, and their rhetorical, persuasive and people skills in the creation of a “climate of cooperation and trust” (Beer, 2003), “participative involvement” (Hackman & Wageman, 1995) or “an environment for cooperation” (Oakland, 1997). Although studies in this realm are helpful and remind us about the contextual element, they do not offer a complete understanding of the role of leadership in the management of shared reality. More importantly, the mainstream of empirical studies is often based on a rationalist and positivistic paradigm. In this realm, the components of TQM that contribute to coordination outcomes often identified as outcome of managers’ efforts, promise few useful application for practitioners.

The fact that this study observed the significant effect of the sensemaking and sensegiving activities at the individual, top management, level that affect those activities at the collective level suggests a need for further studies to investigate how managerial and contextual characteristics affect decision makers’ interpretations. Given that top managers play a central role in interpretation (Daft & Weick, 1984), examining in the process of their decision making, their beliefs, values and ideologies

may provide a better understanding of management's ability to interpret environment contingencies. As Dutton et al. (1990) suggest, differences in contextual conditions also create different motivating conditions for decision makers to construct their environment in particular ways.

Cross-cultural studies may look at how different national backgrounds have influenced staff members' cognitive activities and communication behaviour. Taking the hospital studied as an example, a further examination of differences and similarities in sensemaking and sensegiving activities between the western management team led by an American CEO and the Thai management team could provide a better understanding of how cultural differences can be negotiated in achieving a common goal. This study suggests that the social construction processes that occur naturally in organisations are likely to be one of the key contributors. Besides observing western managerial staff members attempts to adapt to fit the Thais who made up the majority of the hospital staff members, Thais also demonstrated the collectivistic characteristics (Hofstede, 2001; Triandis, 1995) of social interdependence, connectedness, and mutual deference with emotional dependence on family and kinship, within their social system.

Finally, a longitudinal study that examines in-depth the organisational members' sensemaking and sensegiving activities in regard to a particular top management's constructed set of information may enhance the understanding of coordination among subsystem levels. One particular organisational activity that offers this opportunity is the development of organisation's annual plan or policy deployment. For instance, researchers may follow the planning processes that occur at every level of an organisation to examine how the management's constructed information and key strategic directions are interpreted and translated into sub-goals by different departments and identify key factors that contribute to the alignment of the sub-goals to the organisational goals.

7.3.3.2. Multi-Dimensional, Integrative Coordination

The emergence of coordination patterns in the study suggest the need to reconsider a research approach that could accommodate the complex, multi-dimensional nature of coordination which is also driven by communication and reciprocal relationships.

Therefore, studies on coordination could be positioned within a relativist, constructionism or interpretivist paradigm and investigate interrelated multiple ontological domains, not only the conventional organisational structure and configuration, but also cognition, discursive and social interaction.

The fact that this study found that investigation of communication practice through the lens of social construction has revealed a more holistic and richer understanding of the characteristic of coordination has confirmed the equivalency of communication and coordination (Ballard & Seibold, 2003; McPhee & Zaig, 2000). This suggests another useful implication for studying coordination through in-depth observation of communication practices within organisations would allow researcher to capture the fluid and dynamic coordination in its situated nature.

For a richer understanding, the works of scholars such as Cooren (1999, 2004) and Taylor and Van Every (2000) on understanding organising coordination processes through textualisation provide a useful implication for coordination studies, given their argument is based on the realm of action and that of interpretation as constitutive parts of human communication through language. Cooren (2004), in particular, demonstrated a comprehensive empirical research approach by combining organisational communication studies with cognitivism and social psychology in the investigation on how collective minding occurs in communicative interactions. Using in-depth analysis of excerpts from a board meeting, Cooren argues that “a form of collective intelligence can be found more generally in patterns of conversational behaviour” (p.517).

Nevertheless, the pioneering work by Cooren, Taylor and Van Every also has limitations because it tends to offer an extreme view that coordination process lies more in discourse than in structure. To bring balance to the understanding of coordination, Giddens’ (1984) Structuration theory is a potentially useful approach. Giddens’ notion of “duality structure” which highlights the interplay between organisations’ communication structures, organisational interpretative schemes and their communication practices is particularly useful for observation about the dynamics of coordination. Several researchers have adopted Structuration as a theoretical approach in their study on patterns of interaction in work groups (Poole,

Seibold & McPhee, 1996), organisational actors during organisational change (Howard & Grist, 1995) and, social order and the use of technology (Barley, 1986). In addition, Witmer (1997) adopted Structuration as an ontological approach to study organisational communication and culture. These previous studies thus suggest Structuration as a potential perspective that researchers can adopt for their coordination studies.

7.4.Limitations of the Study

Apart from the methodological limitations addressed in Chapter Three, there are some other limitations related to the knowledge produced of this study. The constructed practical theory was based on the data obtained from a particular group of people within one particular organisation and at one designated point of time; whereas the phenomena studied occurred simultaneously, in non-linear manner, and within an interconnected, social system. Despite the best efforts to maintain rigour in the study, this particular practical theory can only serve as a partial understanding of the phenomenon studied.

In addition, although the participants' own accounts were included, this practical theory was a product of the researcher's own interpretation, which was guided by the social constructionism paradigm. The findings of this study could be presented and interpreted differently by other researchers, and/or through the use of a different philosophical perspective. The change in the philosophical underpinning the study also adds another limitation to the study. If social construction had been adopted at the beginning, the design of the study could have corresponded more to the adopted philosophy, and the researcher could have been more reflective in her approach during the data collection.

Another limitation relates to the possibility of bias during the data collection. One possible reason for receiving a considerable amount of positive data may result from two factors. First, there is the impression that the study was conducted for management purposes, given that the researcher was introduced to participants by the senior management members. Second, there may have been an influence from "social desirability" (Edwards, 1957). The hospital studied received several awards for its

successful quality improvement programs and it is likely that staff may have been responding favourably to responses due to expectations generated regarding being a “best practice” organisation. Edwards (1957) identified this social desirability as a principal bias in organisational commitment research.

Finally, the fact that this particular case study was exploratory in nature, based on a relatively small sample, and that the issue of investigation, organisational context, is highly localised make it difficult for the study’s findings to be generalised. Nevertheless, it is believed that there are several key learning issues that can be taken from this particular study, including the potential of investigating communication practices through the lens of social constructionism which offers a more naturalistic and flexible approach. The fact that this study conducted its investigation in an organisation that has been widely accepted internationally as best practice in quality improvement should also provide the key essence of the characteristics and patterns of coordination that could potentially occur within a similar context, and this could be a point of departure for future empirical studies.

REFERENCES

- Adler, P., & Adler, P. (1994). Observational techniques. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 377-392). Thousand Oaks, CA: Sage.
- Adler, P. S., & Kwon, S. (2002). Social capital: Prospects for a new concept. *Academy of Management Review*, 27, 17-40.
- Aghazadeh, S. M. (2002). Implementation of total quality management in the managed care industry. *The TQM Magazine*, 14(2), 79-91.
- Alder, P. S., & Borys, B. (1996). Two types of bureaucracy: Enabling and coercive. *Administrative Science Quarterly*, 41(1), 61-89.
- Allen, B. J. (2005). Social constructionism. In S. May & D. K. Mumby (Eds.), *Engaging organizational communication theory and research: Multiple perspectives* (pp. 35-53). Thousand Oaks, CA: Sage.
- Allen, M. W., & Brady, R. M. (1997). Total quality management, organizational commitment, perceived organizational support, and intraorganizational communication. *Management Communication Quarterly*, 10(3), 316-341.
- Alter, C., & Hage, J. (1993). *Organizations working together*. Thousand Oaks, CA: Sage.
- Alvesson, M. (1993). Organizations as rhetoric: Knowledge-intensive firms and the struggle with ambiguity. *Journal of Management Studies*, 30(6), 997-1015.
- Alvesson, M. (1996). *Communication, power and organization*. Aldine, NY: Hawthorne.
- Alvesson, M., & Deetz, S. (2000). *Doing critical management research*. London: Sage.
- Alvesson, M., & Karreman, D. (2000). On the study of organizations through discourse analysis. *Human Relations*, 53, 1125-1134.
- Alvesson, M., & Skoldberg, K. (2000). *Reflexive methodology*. London: Sage.
- Ambroz, M. (2004). Total quality system as product of the empowered corporate culture. *The TQM Magazine*, 16(2), 93-104.
- Anderson, C. A., & Daigh, R. D. (1991). Quality mindset overcomes barriers to success. *Healthcare Financial Management*, 45(2), 20-32.
- Anderson, J. A., & Baym, G. (2004). Philosophies and philosophic issues in communication, 1995-2004. *Journal of Communication*, 54(4), 589-615.

- Anderson, J. C., Rungtusanatham, M., & Schroeder, R. G. (1994). A theory of quality management underlying the Deming management method. *The Academy of Management Review*, 19(3), 472-509.
- Anderson, R. A., Crabtree, B. F., Steele, D. J., & McDaniel, R. R. J. (2005). Case study research: The view from complexity science. *Qualitative Health Research*, 15(5), 669-685.
- Apker, J., Ford, W. S., & Fox, D. H. (2003). Predicting nurses' organizational and professional identification: The effect of nursing roles, professional autonomy, and supportive communication. *Nurse Economics*, 21(5), 226-232.
- Argote, L. (1982). Input uncertainty and organizational coordination in hospital emergency units. *Administrative Science Quarterly*, 27, 420-434.
- Argyle, M. (1991). *Cooperation: The basis of sociability*. New York: Routledge.
- Argyris, C., & Schon, D. A. (1974). *Theory in practice: Increasing professional effectiveness*. San Francisco: Jossey-Bass Publishers.
- Argyris, C., & Schon, D. A. (1996). *Organizational learning II: Theory, method, and practice*. New York: Addison-Wesley.
- Ashcraft, K.L., & Kedrowicz, A. (2002). Self-direction or social support? Nonprofit empowerment and the tacit employment contract of organizational communication. *Communication Monographs*, 69, 88-110.
- Ashforth, B. E. (1992). The perceived inequity of systems. *Administration and Society*, 24, 375-408.
- Atkinson, P., & Hammersley, M. (1994). Ethnography and participant observation. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research*. London: Sage.
- Babbie, E. (2005). *The basis of social research* (3rd ed.). Ontario, Canada: Thompson Wadsworth.
- Baim, J., & Dimperio, J. (2001). Total quality: A gifted idea may be failing. *School Administrator*, 58(5), 51-53.
- Ballard, D. I., & Seibold, D. R. (2003). Communicating and organizing in time: A meso-level model of organizational temporality. *Management Communication Quarterly*, 16(3), 380-415.
- Ballard, D. I., & Seibold, D. R. (2004). Communication-related organizational structures and work group temporal experiences: The effects of coordination method, technology type, and feedback cycle on members' construals and enactments of time. *Communication Monographs*, 71(1), 1-27.
- Barker, J. (1993). Tightening the iron cage-concertive control in self-managing teams. *Administrative Science Quarterly*, 38, 408-437.

- Barker, R. T., & Camarata, M. R. (1998). The role of communication in creating and maintaining a learning organization: Preconditions, indicators, and disciplines. *The Journal of Business Communication*, 35(4), 443-467.
- Barker, V. E., Abrams, J. R., Tiyaamornwong, V., Seibold, D. R., Duggan, A., Hee, S. P., et al. (2000). New contexts for relational communication in groups. *Small Group Research*, 31(4), 470-503.
- Barki, H., & Pinsonneault, A. (2005). A model of organizational integration, implementation effort, and performance. *Organization Science*, 16(2), 165-179.
- Barley, S.R., & Kunda, G. (2001). Bringing work back in. *Organization Science*, 12(1), 76-95.
- Barnard, C. T. (1938). *The functions of the executive*. Cambridge, MA: Harvard University Press.
- Barrett, F. J., & Thomas, G. F. (1995). The central role of discourse in large-scale change: A social construction perspective. *Journal of Applied Behavioral Science*, 26, 219-239.
- Bass, B. M. (1985). *Leadership and performance beyond expectations*. New York: Free Press.
- Beer, M. (2003). Why total quality management programs do not persist: The role of management quality and implication for leading a TQM transformation. *Decision Sciences*, 34(4), 623-642.
- Beer, M., & Nohria, N. (2000). Cracking the code of change. *Harvard Business Review* (June-July), 133-141.
- Bennis, W., & Nanus, B. (1985). *Leaders: Strategic for taking charge*. New York: Harper & Row.
- Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. London: The Penguin Press.
- Bessant, J., Caffyn, S., Gilbert, J., Harding, R., & Webb, S. (1994). Rediscovering continuous improvement. *Technovation*, 14(1), 17-29.
- Boden, D. (1994). *The business of talk: Organizations in action*. Cambridge: Policy Press.
- Bohm, D. (1996). *On dialogue* (R. Smith, Trans. 2nd ed.). London: Routledge.
- Bolland, J. M., & Wilson, J. V. (1994). Three faces of integrative coordination: A model of interorganizational relations in community-based health and human services. *Health Services Research*, 29(3), 341-367.
- Bolman, L. G., & Deal, T. E. (1997). *Reframing organizations: Artistry, choice, and leadership*. San Francisco: Jossey-Bass Publishers.

- Bordow, A., & More, E. (1991). *Managing organisational communication*. Melbourne, Victoria: Longman Cheshire.
- Bronstein, L. R. (2003). A model for interdisciplinary collaboration. *Social Work*, 48(3), 297-306.
- Brown, A. D., & Starkey, K.P. (1994). The effect of organizational culture in communication and information. *Journal of Management Studies*, 31(6), 807-828.
- Brown, J. E., & Hendry, C. (1997-1998). Industrial districts and supply chains as vehicles for managerial and organisational learning. *International Studies of Management and Organisation*, 27(4), pp.127-157.
- Brown, J. S., & Duguid, P. (2000). *The social life of information*. Boston: Harvard Business School Press.
- Bryman, A. (2004). *Social research methods*. Oxford, United Kingdom: Oxford University Press.
- Burns, J. M. (1978). *Leadership*. New York: Harper & Row.
- Burns, T., & Stalker, G. M. (1961). *Mechanistic and organic system*. California: Brooks/Cole.
- Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.
- Burrell, G., & Morgan, G. (1979). *Sociological paradigms and organisational analysis*. London: Heinemann.
- Burt, R. S. (1992). *Structural holes: The social structure of competition*. Cambridge, MA: Harvard University Press.
- Cairns, G., & Beech, N. (2003). Un-entwining monological narratives of change through dramaturgical and narrative analyses. *Culture and Organization*, 9(3), 177-193.
- Carabelea, C., & Boissier, O. (2006). Coordinating agents in organizations using social commitments. *Electronic Notes in Theoretical Computer Science*, Retrieved October, 19, 2006, from <http://www.emse.fr/~carabele/papers/carabelea.coorg05.pdf>
- Carley, M., & Christie, I. (1992). *Managing sustainable development*. London: Earthscan.
- Chandler, A. D., Jr. (1977). *The visible hand: The managerial revolution in American business*. Cambridge, MA: Harvard University Press.
- Chen, V., & Pearce, W. B. (1995). Even if a thing of beauty, can a case study be a joy forever? A social constructionist approach to theory and research. In W. Leeds-Hurwitz (Ed.), *Social approaches to communication* (pp. 135-154). New York: The Guilford Press.
- Cheney, G. (1983). The rhetoric of identification and the study of organizational communication. *Quarterly Journal of Speech*, 69, 143-158.

- Cheney, G., & Lair, D. J. (2005). Theorizing about rhetoric and organizations. In S. May & D. K. Mumby (Eds.), *Engaging organizational communication theory and research: Multiple perspectives* (pp. 55-84). Thousand Oaks, CA: Sage.
- Cheng, J. L. C. (1983). Interdependence and coordination in organizations: A role-system analysis. *Academy of Management Journal*, 26(1), 156-162.
- Cheng, J. L. C., & Miller, E. L. (1985). Coordination and output attainment in work units performing nonroutine tasks: A cross-national study. *Organization Studies*, 6, 23-39.
- Child, J. (1997). Strategic choice in the analysis of action, structure, organizations and environment: Retrospect and prospect. *Organization Studies*, 18(1), 43-76.
- Chisholm, D. (1989). *Coordination without hierarchy: Informal structures in multiorganisational systems*. California: University of California Press.
- Chow-Chua, C., & Goh, M. (2000). Quality improvement in the healthcare industry: Some evidence from Singapore. *International Journal of Health Care Quality Assurance*, 13(5), 223-229.
- Clark, H. H., & Brennan, S. E. (1991). Grounding in communication. In L. Resnick, J. Levine & S. D. Teasley (Eds.), *Perspective on socially shared cognition*. Washington, DC: American Psychological Association.
- Cochrane, J. (2006). Medical meccas. *Newsweek International Edition*, October 30, Retrieved December 1, 2006, from <http://www.msnbc.msn.com/id/15365149/site/newsweek/>
- Cole, R. E., & Scott, R. W. (Eds.). (1999). *The quality movement and organization theory*. Thousand Oaks, CA: Sage.
- Cooren, F. (1999). Applying socio-semiotics to organizational communication: A new approach. *Management Communication Quarterly*, 13(2), 194-304.
- Cooren, F. (2004). The communicative achievement of collective minding: Analysis of board meetings excerpts. *Management Communication Quarterly*, 17(4), 517-551.
- Cornelissen, J. P., & Lock, A. R. (2000). Theoretical concept or management fashion? Examining the significance of IMC. *Journal of Advertising Research*, 40(5), 7.
- Costello, D. E., & Pettegrew, L. S. (1979). Health communication theory and research: An overview of health organizations. In D. Nimmo (Ed.), *The communication yearbook 3*. (pp. 607-623). New Jersey: Transaction Books.
- Couch, C. J. (1984). Symbolic interaction and generic sociological principles. *Symbolic interaction*, 7, 1-13.
- Couch, C. J. (1992). Toward a formal theory of social process. *Social Interaction*, 15, 117-134.

- Cox, T. H., Lobel, S. A., & McLeod, P. L. (1992). Effects of ethnic group cultural differences on cooperative and competitive behaviour on a group task. *Academy of Management Journal*, 34, 827-847.
- Crabtree, B., & Miller, W. (1999). *Doing qualitative research*. Thousand Oaks, California: Sage.
- Creswell, J.W. (1994). *Research design: Qualitative and quantitative approaches*. London: Sage.
- Cronen, V. E. (1995). Practical theory and the tasks ahead for social approaches to communication. In W. Leeds-Hurwitz (Ed.), *Social approaches to communication* (pp. 217-242). New York: The Guilford Press.
- Crosby, P. B. (1979). *Quality is free: The art of making quality certain*. New York: Mentor Books.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. NSW, Australia: Allen & Unwin.
- Crowston, K. (1997). A coordination theory approach to organizational process design. *Organisation Science*, 8(2), 157-175.
- Cullen, J. (2004). Identifying sectoral management cultures through recruitment advertising. *Leadership & Organization Development Journal*, 25(3), 279-291.
- Cyert, R. M., & March, J. G. (1992). *A behavioural theory of the firm*. Cambridge, MA: Blackwell.
- Czarniawska-Joerges, B., & Joerges, B. (1988). How to control things with words: Organizational talk and control. *Management Communication Quarterly*, 2(2), 170-193.
- Daft, R. L., & Weick, K. E. (1984). Towards a model of organisations as interpretation systems. *Academy of Management Review*, 9(2), 284-295.
- Day, G. S. (1994). The capabilities of market-driven organizations. *Journal of Marketing*, 58(4), 37-53.
- Deal, T. E., & Kennedy, A. A. (1982). *Corporate cultures: The rites and rituals of corporate life*. Reading, MA: Addison-Wesley.
- Dean, J. W., & Bowen, D. E. (1994). Management theory and total quality: Improving research and practice through theory development. *Academy of Management Journal*, 19(3), 392-418.
- Deetz, S. (2001). Conceptual foundations. In F. M. Jablin & L. Putnam (Eds.), *The new handbook of organizational communication: Advances in theory, research, and methods* (pp. 3-46). Thousand Oaks, CA: Sage.

- Deming, W. E. (1986). *Out of the crisis*. Cambridge, United Kingdom: Cambridge University Press.
- Deming, W. E. (1992). *A system of profound knowledge*. Knoxville, TN: SPC Press.
- Deming, W. E. (1993). *The new economics for industry, government, education*. Cambridge, MA: Massachusetts Institute of Technology Centre for Advance Engineering Study.
- Denison, D. R. (1990). *Corporate culture and organizational effectiveness*. New York: Wiley.
- Denzin, N. K. (1989). *Interpretive interactionism*. Newbury Park, CA: Sage.
- Denzin, N. K. (1996). *Interpretive ethnography: Ethnographic practice for the 21st century*. Thousand Oaks, CA: Sage.
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005). *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.
- Dervitsiotis, K. N. (2002). The importance of conversations-for-action for effective strategic management. *Total Quality Management, 13*(8), 1087-1098.
- DeSanctis, G., & Poole, M. S. (1994). Capturing the complexity in advance technology use: Adaptive structuration theory. *Organization Science, 5*(2), 121-147.
- Detert, J. R., Schroeder, R. G., & Muriel, J. J. (2000). A framework for linking culture and improvement initiatives in organizations. *Academy of Management Review, 25*(4), 850-878.
- Dey, I. (1993). *Qualitative data analysis: A user friendly guide to social scientists*. London: Routledge.
- DiMaggio, P. J., & Powell, W. W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *American Sociological Review, 48*, 147-160.
- DiMaggio, P. J., & Powell, W. W. (1991). Introduction. In W. W. Powell & P. J. DiMaggio (Eds.), *The new institutionalism in organizational analysis* (pp. 1-38). Chicago: University of Chicago Press.
- Dingwall, M. (1997). Accounts, interviews and observations in context and method. In G. Miller & R. Dingwall (Eds.), *Qualitative research* (pp. 51-65). London: Sage.
- Donnellon, A., Gray, B., & Bougon, M. (1986). Communication, meaning, and organized action. *Administrative Science Quarterly, 31*, 43-55.
- Dooley, L.M. (2002). Case study research and theory building. *Advances in Developing Human Resources, 4*(3), 335-354.

- Dublin, R. (1978). *Theory building*. New York: Free Press.
- Duncan, H. D. (1962). *Communication and social order*. London: Oxford University Press.
- Duncan, T., & Moriarty, S. E. (1998). A communication-based marketing model for managing relationships. *Journal of Marketing*, 62(2), 1-13.
- Duncan, T. R., & Everett, S. E. (1993). Client perceptions of integrated marketing communications. *Journal of Advertising Research*, 33(3), 30-40.
- Dutton, J. E., Stumpf, S., & Wagner, D. (1990). Diagnosing strategic issues and managerial investment of resources. In R. Lamb & P. Shrivasteria (Eds.), *Advances in strategic management* (pp.143-167). Greenwich, CT: JAI Press.
- Eagle, L., Kitchen, P., Hyde, K., Fourie, W., & Padiseti, M. (1999). Perceptions of integrated marketing communications among marketers & ad agency executives in New Zealand. *International Journal of Advertising*, 18(1), 89-119.
- Edwards, A. L. (1957). *The social desirability variable in personality assessment and research*. New York: Dryden.
- Egan, T.M. (2002). Grounded theory research and theory building. *Advances in Developing Human Resources*, 4(3), 277-295.
- Ehigie, B. O., & Akpan, R. C. (2006). Roles of personality attributes in the practice of total quality management. *Individual Differences Research*, 4(2), 78-105.
- Ehigie, B. O., & McAndrew, E. B. (2005). Innovation, diffusion, and adaptation of total quality management. *Management Decision*, 43(6), 925-940.
- Eisenberg, E. M. (1984). Ambiguity as strategy in organizational communication. *Communication Monographs*, 51, 227-242.
- Eisenberg, E. M., & Riley, P. (2001). Organizational culture. In F. M. Jablin & L. L. Putnam (Eds.), *The new handbook of organizational communication: Advances in theory, research, and methods* (pp. 291-322). Thousand Oaks, CA: Sage.
- Eisenhardt, K. M. (1989). Building theory from case study research. *Academy of Management Review*, 14(4), 532-550.
- Ennis, K., & Harrington, D. (1999). Quality management in Irish health care. *International Journal of Health Care Quality Assurance*, 12(6), 232-243.
- Ensign, P. C. (1998). Interdependence, coordination, and structure in complex organization: Implications for organization design. *Mid-Atlantic Journal of Business*, 34(1), 5-53.
- Evered, R., & Louis, M. R. (1981). Alternative perspectives in the organizational sciences: Inquiry from the inside and inquiry from the outside. *Academy of Management Review*, 3(3), 385-395.

- Fairhurst, G. T. (1993). Echoes of the vision: When the rest of the organization talks total quality. *Management Communication Quarterly*, 6, 331-371.
- Fairhurst, G. T. (2001). Dualisms in leadership research. In F. M. Jablin & L. L. Putnam (Eds.), *The new handbook of organizational communication: Advances in theory, research, and methods* (pp. 291-322). Thousand Oaks, CA: Sage.
- Fairhurst, G. T., & Chandler, T. A. (1989). Social structure in leader-member interaction. *Communication Monographs*, 56, 215-239.
- Fairhurst, G. T., & Putnam, L. (2004). Organizations as discursive constructions. *Communication Theory*, 14, 5-26.
- Fairhurst, G. T., & Sarr, R. A. (1996). *The art of framing: Managing the language of leadership*. San Francisco: Jossey-Bass Publishers.
- Fairhurst, G. T., & Wendt, R. F. (1993). The gap in total quality: A commentary. *Management Communication Quarterly*, 6, 441-451.
- Falcione, R. L., Sussman, L., & Herden, R. P. (1987). Communication climate in organizations. In F. M. Jablin, L. L. Putnam, K. H. Roberts & L. W. Porter (Eds.), *Handbook of organizational communication* (pp. 195-228). Newbury Park, CA: Sage.
- Farrell, A., & Geist-Martin, P. (2005). Communicating social health: Perceptions of wellness at work. *Management Communication Quarterly*, 18(4), 543-592.
- Feigenbaum, A. V. (1961). *Total quality control*. New York: McGraw-Hill.
- Fill, C. (2001). Essentially a matter of consistency: Integrated marketing communications. *The Marketing Review*, 1, 409-425.
- Fiske, S. T., & Taylor, S. E. (1991). *Social cognition* (2 ed.). New York: McGraw-Hill.
- Flynn, F. J. (2005). Identity orientations and forms of social exchange in organizations. *Academy of Management Review*, 30(4), 737-750.
- Ford, J. D., & Ford, L. W. (1994). Logics of identity, contradiction, and attraction in change. *Academy of Management Review*, 19, 756-785.
- Ford, J. D., & Ford, L. W. (1995). The role conversations in producing intentional change in organizations. *Academy of Management Review*, 20, 541-571.
- Frijda, N. H. (1988). The laws of emotion. *American Psychologist*, 43, 349-358.
- Fritz, J. M. (2002). How do I dislike thee? Let me count the ways: Constructing impressions of troublesome others at work. *Management Communication Quarterly*, 15(3), 410-438.
- Fulk, J. (1993). Social construction of communication technology. *Academy of Management Journal*, 36, 921-950.

- Galbraith, J. R. (1973). *Designing complex organizations*. Reading, MA: Addison-Wesley.
- Galbraith, J. R. (1977). *Organization design*. Reading, MA: Addison-Wesley.
- Geertz, C. (1973). *Interpretations of cultures*. New York: Basic Books.
- Geertz, C. (1983). *Local knowledge: Further essays in interpretive anthropology*. New York: Basic Books.
- Gergen, K. J. (1999). *An invitation to social construction*. London: Sage.
- Ghoshal, S., & Bartlett, C. A. (1997). *The individual corporation*. New York: Harper Business.
- Gibb, J. (1961). Defensive communication. *Journal of Communication*, 11(3), 141-148.
- Giddens, A. (1984). *The constitution of society*. Berkeley, CA: University of California Press.
- Gilsdorf, J. W. (1998). Organizational rules on communicating: How employees are and are not learning the ropes. *The Journal of Business Communication*, 35(2), 173-201.
- Gioia, D. A., & Chittipeddi, K. (1991). Sensemaking and sensegiving in strategic change initiation. *Strategic Management Journal*, 12(6), 433-448.
- Gioia, D. A., & Pitre, E. (1990). Multiparadigm perspective on theory building. *Journal of Management Review*, 15(4), 584-602.
- Gioia, D. A., Thomas, J. B., Clark, S. M., & Chittipeddi, K. (1994). Symbolism and strategic change in academia: The dynamics of sensemaking and influence. *Organisation Science*, 5(3), 363-383.
- Gittell, J. D. (2000). Organizing work to support relational co-ordination. *International Journal of Human Resource Management*, 11(3), 517-539.
- Gittell, J. D. (2001). Supervisory span, relational coordination and flight departure performance: A reassessment of post bureaucracy theory. *Organization Science*, 12(4), 468-483.
- Gittell, J. H. (2002). Coordinating mechanisms in care provider groups: Relational coordination as a mediator and input uncertainty as a moderator of performance effects. *Management Science*, 48(11), 1408-1426.
- Gittell, J. H., & Weiss, L. (2004). Coordination networks within and across organizations: A multi-level framework. *Journal of Management Studies*, 41(1), 127-153.
- Glaser, B.G. (1978). *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*. Mill Valley, California: Sociology Press.
- Glaser, B.G., & Strauss, A. (1967). *The discovery of grounded theory: Strategies of qualitative research*. London: Weidenfeld and Nicholson.

- Gomm, R. (2004). *Social research methodology: A critical introduction*. New York: Palgrave Macmillan.
- Gould, S. J. (2004). IMC as theory and as a poststructural set of practices and discourses: A continuously evolving paradigm shift. *Journal of Advertising Research*, 44(1), 66-70.
- Gould, S. J., Lerman, D. B., & Grein, A. F. (1999). Agency perceptions and practices on global IMC. *Journal of Advertising Research*, 39(1), 7.
- Gouran, D. S. (1999). Communication in groups: The emergence and evolution of a field of study. In L. R. Frey, D. S. Gouran & M. S. Poole (Eds.), *The handbook of group communication and group decision-making*. Beverly Hills, CA: Sage.
- Gresov, C., & Stephens, C. (1993). The context of interunit influence attempts. *Administrative Science Quarterly*, 38(2), 252-276.
- Gronn, P. C. (1983). Talk as the works: The accomplishment of school administration. *Administrative Science Quarterly*, 28(1), 1-21.
- Gronroos, C. (2004). The relationship marketing process: Communication, interaction, dialogue, value. *Journal of Business & Industrial Marketing*, 19(2), 99-113.
- Gronstedt, A. (1996). Integrated communications at America's leading total quality management corporations. *Public Relations Review*, 22(1), 25-43.
- Gronstedt, A. (2000). *The customer century*. New York: Routledge.
- Guba, E., & Lincoln, Y. S. (1998). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (pp. 195-220). London: Sage.
- Gummesson, E. (1988). *Qualitative methods in management research*. Lund, Norway: Studentlitterature.
- Gupta, P. P., Dirsmith, M. W., & Fogarty, T. J. (1994). Coordination and control in a government agency: Contingency and institutional theory perspective on GAO audits. *Administrative Science Quarterly*, 39(2), 264-284.
- Hackman, J. R., & Oldham, G. R. (1980). *Work redesign*. Reading, MA: Addison-Wesley.
- Hackman, J. R., & Wageman, R. (1995). Total quality management: Empirical, conceptual, and practical issues. *Administrative Science Quarterly*, 40(2), 309-342.
- Hammersley, M., & Atkinson, P. (1983). *Ethnography: Principles in practice*. London: Tavistock.
- Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in practice*. (2nd eds.). London: Routledge.

- Hardin, C., & Higgins, E. T. (1995). Shared reality: How social verification makes the subjective objective? In R. M. Sorrentino & E. T. Higgins (Eds.), *Handbook of motivation and cognition: Foundations of social behavior* (Vol. 3). New York: Guilford.
- Hardy, C., Lawrence, T. B., & Phillips, N. (1998). Talk and action: Conversations and narrative in interorganizational collaboration. In D. Grant, T. Keenoy & C. Osrick (Eds.), *Discourse + organisation* (pp. 65-83). London: Sage.
- Hargie, O., & Tourish, D. (2000). *Handbook of communication audits for organisations*. London: Routledge.
- Harrington, H. J. (1997). The fallacy of universal best practices. *The TQM Magazine*, (9), 61-75.
- Hass, J. W., Davenport-Sypher, B., & Sypher, H. E. (1992). Do shared goals really make a difference? *Management Communication Quarterly*, 6, 166-179.
- Hassard, J. (1993). *Sociology and organization theory*. Cambridge, United Kingdom: Cambridge University Press.
- Heath, C., & Staudenmayer, N. (2000). Coordination neglect: How lay theories of organizing complicate coordination in organizations. *Research in Organizational Behaviour*, 22, 153-191.
- Hill, S. (1991). Why quality circles failed but total quality management might succeed? *British Journal of Industrial Relations*, 29(4), 541-568.
- Hill, S. (1995). From quality circles to total quality management. In A. Wilkinson & H. Willmott (Eds.), *Making quality critical: New perspectives on organisational change*. London: Routledge.
- Hofstede, G. (2001). *Culture's consequences: Comparing values, behaviours, institutions, and organizations across nations* (2nd ed.). Thousand Oaks, CA: Sage.
- Holliday, A. (2002). *Doing and writing qualitative research*. Thousand Oaks, CA: Sage.
- Hoogervorst, J., Flier, H. V. D., & Koopman, P. (2004). Implicit communication in organizations: The impact of culture, structure and management practice on employee behavior. *Journal of Managerial Psychology*, 19(3), 288-311.
- House, R. J., & Howell, J. M. (1992). Personality and charismatic leadership. *Leadership Quarterly*, 3, 81-108.
- Howell, J. M., & Avolio, H. J. (1993). Transformational leadership, transactional leadership, locus of control, and support for innovation: Key predictors of consolidated-business-unit performance. *Journal of Applied Psychology*, 78, 891-902.

- Hruby, G. G. (2001). Sociological, postmodern, and new realism perspectives in social constructionism: Implications for literacy research. *Reading Research Quarterly*, 36(1), 48-62.
- Hu, X. X. (2003). *Improving quality while reducing cost? An innovation journey*. Ph.D. dissertation, University of New South Wales, NSW, Australia.
- Huxham, C., & Vangen, S. (2000). Ambiguity, complexity and dynamics in the membership of collaboration. *Human Relations*, 53(6), 771-806.
- Huxham, C., & Vangen, S. (2005). *Managing to collaborate: The theory and practice of collaborative advantage*. New York: Routledge.
- Isaacs, W. N. (1993). Taking flight: Dialogue, collective thinking, and organizational learning. *Organizational Dynamics*, 22(2), 24-40.
- Ishikawa, K. (1985). *What is total quality control? The Japanese way*. Englewood Cliffs, NJ: Prentice Hall.
- Jablin, F. M. (1979). Superior-subordinate communication: The state-of-the-art. *Psychological Bulletin*, 86, 1201-1222.
- Jablin, F. M., Putnam, L. L., Roberts, K. H., & Porter, L. W. (Eds.). (1987). *Handbook of organizational communication: An interdisciplinary perspective*. Newbury Park, CA: Sage.
- Jacob, N. (2005). Cross-cultural investigations: Emerging concepts. *Journal of Organizational Change Management*, 18(5), 514-528.
- James, P. T. J. (1996). *Total quality management: An introductory text*. New York: Prentice Hall.
- Janesick, V. (2004). *Stretching exercises for qualitative researchers* (2nd ed.). Thousand Oaks, CA: Sage.
- Jenni, R. J., & Mauriel, J. (2004). Cooperation and collaboration: Reality or rhetoric. *International Journal of Leadership in Education*, 7(2), 181-195.
- Jorgensen, D. L. (1993). *Participant Observation*. London: Sage.
- Juran, J. M. (1991). Strategies or world-class quality. *Quality Progress*, (March), 81-85.
- Karnoe, P. (1997). Only in social action. *American Behavioral Scientist*, 40(4), 419-430.
- Katudat, S. (1990). *Middle path for the future of Thailand: Technology in harmony with culture and environment*. Bangkok, Thailand: Thai Wattana Panich Press.
- Kelemen, M. (2000). Too much or too little ambiguity: The language of total quality management. *Journal of Management Studies*, 37(4), 485-501.

- Kenji, G. K., & Asher, M. (1993). *Total quality management process: A systematic approach*. Oxford, United Kingdom: Carfax.
- Kennedy, K. N., Goolsby, J. R., & Arnould, E. J. (2003). Implementing a customer orientation: Extension of theory and application. *Journal of Marketing*, 67(4), 67-82.
- Keyton, J. (2005). *Communication and organizational culture*. Thousand Oaks, CA: Sage Publications.
- Kincheloe, J. L. (2005). On to the next level: Continuing the conceptualization of the bricolage. *Qualitative Inquiry*, 11(3), 323-350.
- Kitchen, P. J., Brignell, J., Li, T., & Jones, G., S. (2004). The emergence of IMC: A theoretical perspective. *Journal of Advertising Research*, 44(1), 19-30.
- Kitchen, P., & Schultz, D. (1999). A multi-country comparison of the drive for IMC. *Journal of Advertising Research*, 39(1), 21-38.
- Klausner, W. J. (1987). *Reflections on Thai culture* (3rd ed.). Bangkok, Thailand: Amerin Printing Group.
- Kliatchko, J. (2005). Towards a new definition of integrated marketing communications (IMC). *International Journal of Advertising*, 24(1), 7-34.
- Komin, S. (1990). Culture and work-related values in Thai organizations. *International Journal of Psychology*, 25, 681-704.
- Koopman, P. L. (1991). Between control and commitment: Management and change as the art of balancing. *The Leadership & Organizational Development Journal*, 12(5), 3-7.
- Kotter, J. P., & Heskett, J. L. (1992). *Organizational culture and performance*. New York: Free Press.
- Krone, K. J., Jablin, F. M., & Putnam, L. L. (1987). Communication theory and organizational communication: Multiple perspectives. In F. M. Jablin, L. L. Putnam, K. H. Roberts & L. W. Porter (Eds.), *Handbook of organizational communication: An interdisciplinary perspective* (pp. 18-40). Newbury Park, CA: Sage.
- Kunst, P., & Lemmink, J. (2000). Quality management and business performance in hospitals: A search for success parameters. *Total Quality Management*, 11(8), 1123-1133.
- Larkin, T., & Larkin, S. (1994). *Communication change*. New York: McGraw-Hill.
- Larsson, R., & Bowen, D. E. (1989). Organization and customer: Managing design and coordination of services. *Academy of Management Review*, 14(2), 213-133.
- Latour, B. (1987). *Science in action: How to follow scientists and engineers through society*. Milton Keynes, Buckinghamshire: Open University Press.

- Lawler, E. E. (1994). Total quality management and the employee involvement: Are they compatible? *The Academy of Management Executive*, 8(1), 68-77.
- Lawrence, P., & Lorsch, J. (1967). Differentiation and integration in complex organizations. *Administrative Science Quarterly*, 12, 1-47.
- Lea, M., O'Shea, T., & Fung, P. (1995). Constructing the networked organization: Content and context in the development of electronic communications. *Organisation Science*, 6(4), 462-478.
- Lee, J. (1997). Leader-member exchange, the "Pelz effect," and cooperative communication between group members. *Management Communication Quarterly*, 11, 266-287.
- Lee, J., & Jablin, F. M. (1995). Maintenance communication in superior-subordinate work relationships. *Human Communication Research*, 22, 220-257.
- Leeds-Hurwitz, W. (Ed.). (1995). *Social approaches to communication*. New York: The Guilford Press.
- Lemak, D. J., & Reed, R. (2000). An applications of Thompson's typology to TQM in service firms. *Journal of Quality Management*, 5, 67-83.
- Leonard, D., & McAdam, P. (2001). Grounded theory methodology and practitioner reflexivity in TQM research. *The International Journal of Quality & Reliability Management*, 18(2), 180-194.
- Lewis, L. K. (1999). Disseminating information and soliciting input during planned organizational change: Implementers' targets, sources and channels for communicating. *Management Communication Quarterly*, 13, 43-75.
- Lewis, L. K. (2000). Communicating change: Four cases of quality programs. *The Journal of Business Communication*, 37(2), 128-155.
- Lewis, L.K., & Seibold, D.R. (1993). Innovation modification during intraorganizational adoption. *Academy of Management Review*, 18, 322-354.
- Likert, R. (1965). *New patterns of management*. New York: McGraw-Hill.
- Lillrank, P. (2003). The quality of standard, routine and nonroutine processes. *Organization Studies*, 24(2), 215-233.
- Lillrank, P., Shani, A. B., & Lindberg, P. (2001). Continuous improvement: Exploring alternative organizational designs. *Total Quality Management*, 12(1), 41-55.
- Lin, Y. C. (2000-2001). Assessing the applicability of integrated communications: A systemic approach. *Journal of Integrated Communications*, 46-51.
- Locke, E. A., & Schweiger, D. M. (1979). Participation in decision making: One more look. In B. M. Staw (Ed.), *Research in organisational behaviour*, (pp. 265-339). Greenwich, CT: JAI Press.

- Macpherson, I., Brooker, R., & Ainsworth, P. (2000). Case study in the contemporary world of research: Using notions of purpose, place, process and product to develop some principles for practice. *International Journal of Social Research Methodology*, 3(1), 49-61.
- Mahmood, Z. (2000). *An empirical investigation of the successful implementation of quality management in service organisations*. Ph.D. dissertation, University of Western Sydney, NSW, Australia.
- Malone, T. W., & Crowston, K. (1994). The interdisciplinary study of coordination. *Computing Surveys*, 26(1), 87-119.
- March, J., & Simon, H. (1958). *Organizations*. New York: Wiley.
- Marsden, N., & Kanji, G. K. (1998). The use of Hoshin Kanri planning and deployment systems in the service sector: An exploration. *Total Quality Management*, 9(4/5), 167-171.
- Marshall, E. M. (1995). The collaborative workplace. *Management Review*, 84(6), 13-18.
- Martin, J. (2002). *Organizational culture: Mapping the terrain*. Thousand Oaks, CA: Sage.
- May, S., & Mumby, D. K. (2005). Introduction: Thinking about engagement. In S. May & D. K. Mumby (Eds.), *Engaging organizational communication theory and research: Multiple perspectives* (pp. 1-14). Thousand Oaks, CA: Sage.
- McAdam, R., Leitch, C., & Harrison, R. (1998). The links between organizational learning and total quality: A critical view. *Journal of European Industrial Training*, 22(2), 47-56.
- McGregor, D. M. (1960). *The human side of enterprise*. New York: McGraw-Hill.
- McPhee, R. D., & Zaug, P. (2000, February). *The communicative construction of organizations: A framework for explanation*. Paper presented at the annual meeting of the Western States Communication Association, Sacramento, CA.
- Merriam-Webster's collegiate dictionary* (11th ed.). (2004). Springfield, MA: Merriam-Webster.
- Meyer, J. W., & Rowan, B. (1977). Institutional environments and organizations: Structural complexity and individualism. *American Journal of Sociology*, 83, 340-363.
- Meyer, J. W., & Scott, R. W. (1983). *Organizational environments: Ritual and rationality*. Beverly Hills, CA: Sage.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Miller, K. (2003). *Organizational communication: Approaches and processes*. Belmont, CA: Wadsworth/Thomson Learning.

- Milliken, F. J., Morrison, E. W., & Hewlin, P. F. (2003). An exploratory study of employee silence: Issues that employees don't communicate upward and why. *Journal of Management Studies*, 40(6), 1453-1476.
- Minssen, H. (2005). Challenges of teamwork in production: Demands of communication, *Organization Studies Online First*: Sage Publications.
- Mintzberg, H. (1979). *The structuring of organizations: A synthesis of the research*. Englewood Cliffee, NJ: Prentice-Hall.
- Mintzberg, H., Jorgensen, J., Dougherty, D., & Westley, F. (1996). Some surprising things about collaboration - knowing how people connect makes it work better. *Organizational Dynamics*, 25(1), 60-72.
- Mitchell, J. C. (1983). Case and situation analysis. *Sociology Review*, 51(2), 187-211.
- Mohr, J., & Nevin, J. R. (1990). Communication strategies in marketing channels: A theoretical perspective. *Journal of Marketing*, 54(4), 36-51.
- Mole, R. L. (1973). *Thai values and behaviour patterns*. Rutland, VT: Charles E. Tuttle Company.
- Morgan, G., & Smircich, L. (1980). The case for qualitative research. *Academy of Management Review*, 5, 491-500.
- Morse, J.M., & Field, P.A. (1996). *Nursing Research: The application of qualitative approaches* (2nd ed.) London: Chapman & Hall.
- Morse, J. M., & Richards, L. (2002). *Read me first for a user's guide to qualitative methods*. Thousand Oaks, CA: Sage.
- Motwani, J. G., Sower, V. E., & Brashier, L. W. (1996). Implementing TQM in the health care sector. *Health Care Management Review*, 21(1), 73-82.
- Mulder, N. (2000). *Inside Thai society*. Chiang Mai, Thailand: Silkworm Books.
- Mumby, D. (1989). Ideology and the social construction of meaning: A communication perspective. *Communication Quarterly*, 37, 18-25.
- Muscat, R. J. (1990). *Thailand and the United States: Development, security, and foreign aid*. New York: Columbia University Press.
- Nadler, D. A., & Tushman, M. L. (1997). *Competing by design: The power of organizational architecture*. New York: Oxford University Press.
- Nohria, N., & Eccles, R. G. (1992). *Networks and organizations: Structure, form, and action*. Boston: Harvard Business School Press.
- O'Reilly, C. (1989). Corporations, culture and commitment: Motivation and social control in organizations. *California Management Review*, 31(4), 9-25.

- Oakland, J. S. (1997). Interdependence and cooperation: The essentials of total quality management. *Total Quality Management*, 8(2&3), 31-35.
- Oakland, J. S. (2004). *Oakland on quality management*. Oxford, United Kingdom: Elsevier Butterworth Heinemann.
- Olian, J. D., & Rynes, S. L. (1991). Making total quality work: Aligning organizational process, performance measures, and stakeholders. *Human Resource Management*, 30, 303-333.
- Orlikowski, W. J. (1994). Genre repertoire: The structuring of communicative practices in organizations. *Administrative Science Quarterly*, 39(4), 541-574.
- Ovretveit, J. (2000). Total quality management in European healthcare. *International Journal of Health Care Quality Assurance*, 13(2), 74-79.
- Pacanowsky, M. E., & O'Donnell-Trujillo, N. (1983). Organizational communication as cultural performance. *Communication Monographs*, 50, 126-147.
- Pasmore, W. (1988). *Designing effective organisations: The sociotechnical system perspective*. New York: Wiley.
- Patterson, M., Payne, R., & West, M. (1996). Collective climates: A test of their sociopsychological significance. *Academy of Management Journal*, 39(6), 1675-1692.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, California: Sage.
- Pearce, W. B. (1995). A sailing guide for social constructionist. In W. Leeds-Hurwitz (Ed.), *Social approaches to communication* (pp. 88-113). New York: The Guilford Press.
- Perlow, L. A., Gittell, J. H., & Katz, N. (2004). Contextualizing patterns of work group interaction: Toward a nested theory of structuration. *Organization Science*, 15(5), 520-536.
- Peters, T. J., & Waterman, R. H. (1995). *In search of excellence: Lessons from America's best run companies*. London: Harper Collins.
- Pettegrew, L. (1999-2000). If IMC is so good, why isn't it being implemented? Barriers to IMC adoption in corporate America. *Journal of Integrated Communications*, 29-37.
- Pettigrew, A. M., Woodman, R. W., & Cameron, K. S. (2001). Studying organizational change and development: Challenges for future research. *Academy of Management Journal*, 4, 697-713.
- Pfeffer, J. (1981). Management as symbolic action: The creation and maintenance of organisational paradigms. In L. L. Cummings & B. M. Staw (Eds.), *Research in organisational behaviour* (pp. 1-52). Greenwich, CT: JAI.

- Pfeffer, J., & Salancik, G. R. (1978). *The external control of organizations*. New York: Harper & Row.
- Pickton, D., & Hartley, B. (1998). Measuring integration: An assessment of the quality of integrated marketing communication. *International Journal of Advertising*, 17(4), 447-465.
- Podolny, J. M., & Baron, J. N. (1997). Resources and relationships: Social networks and mobility in the workplace. *American Sociological Review*, 62, 673-693.
- Pondy, L. R. (1977). The other hand clapping: An information processing approach to organizational power. In T. H. Hammer & S. B. Bacharach (Eds.), *Reward systems and power distribution in organizations* (pp. 56-91). New York: Cornell University Press.
- Pongpirul, K., Sriratanaban, J., Asavaroengchai, S., Thammatacharee, J., & Laoitthi, P. (2006). Comparison of health care professionals' and surveyors' opinions on problems and obstacles in implementing quality management system in Thailand: A national survey. *International Journal for Quality in Health Care*, 18(5), 346-351.
- Pool, S. W. (2000). The learning organization: Motivating employees by integrating TQM philosophy in a supportive organizational culture. *Leadership & Organization Development Journal*, 21(8), 373-378.
- Poole, M.S., & DeSanctis, G. (1990). Understanding the use of group decision group support systems: The theory of adaptive Structuration. In J. Fulk & C. Steinfeld (Eds.), *Organizations and communication technology* (pp. 173-193). Newbury Park, CA: Sage.
- Poole, M. S., & McPhee, R. D. (1983). A structural analysis of organizational climate. In L. L. Putnam & M. E. Pacanowsky (Eds.), *Communication and organizations: An interpretive approach*. Beverly Hills, CA: Sage.
- Prasad, A. (2002). The contest over meaning: Hermeneutics as an interpretive methodology for understanding texts. *Organizational Research Methods*, 5(1), 12-33.
- Putnam, L. (1983a). Preface. In Putnam, L.L. & M.E., Pacanowsky (Eds.). *Communication and organisations: An interpretive approach*. Sage, California.
- Putnam, L. L. (1983b). The interpretive perspective: An alternative to functionalism. In L. L. Putnam & M. E. Pacanowsky (Eds.), *Communication and organisations: An interpretive approach* (pp. 31-54). Beverly Hills, CA: Sage.
- Putnam, L. L. (1999). Shifting metaphors of organizational communication: The rise of discourse. In P. Salem (Ed.), *Organizational communication and change*. New Jersey: Hampton Press.
- Rago, W. V. (1996). Struggles in transformation: A study in TQM, leadership, and organisational culture in a government agency. *Public Administration Review*, 56(3), 227-234.

- Ranson, S., Hinings, B., & Greenwood, R. (1980). The structuring of organizational structures. *Administrative Science Quarterly*, 25, 1-17.
- Redding, W. C. (1972). *Communication within the organization: An interpretive review of theory and research*. New York: Industrial Communication Council.
- Reger, R., Gustafson, L., Demarie, S., & Mullane, J. (1994). Reframing the organization: Why implementing total quality is easier said than done. *The Academy of Management Review*, 19(3), 565-584.
- Ring, P. S., & Van de Ven, A. H. (1992). Structuring cooperative relationships between organizations. *Strategic Management Journal*, 13, 483-498.
- Robson, C. (2002). *Real world research: a resource for social scientists and practitioner-researchers*. (2nd ed). Oxford: Blackwell
- Rukhamate, P. (2003). *ISO adoption in Thai public hospitals: Institutional and strategic choice perspective*. Ph.D dissertation, National Institution of Development Administration, Bangkok, Thailand.
- Salancik, G. R., & Pfeffer, J. (1978). A social information processing approach to job attitudes and task design. *Administrative Science Quarterly*, 23(2), 224-253.
- Sale, J. E., Lohfeld, L. H., & Brazil, K. (2002). Revisiting the quantitative-qualitative debate: Implications for mixed methods research. *Quality and Quantity*, 36(1), 43-53.
- Sandberg, J. (2005). How do we justify knowledge produced within interpretive approaches? *Organizational Research Methods*, 8(1), 41-68.
- Sarantakos, S. (2005). *Social research* (3rd ed.). New York: Palgrave Macmillan.
- Sarason, S., & Lorentz, E. M. (1998). *Crossing boundaries: Collaboration, co-ordination and the redefinition of boundaries*. San Francisco: Jossey-Bass.
- Saskin, M., & Kiser, K. J. (1993). *Putting total quality management to work: What TQM means, how to use it & how to sustain it over the long run*. San Francisco: Jossey-Bass.
- Savolainen, T. (2000). Leadership strategies for gaining business excellence through total quality management: A Finnish case study. *Total Quality Management*, 11(2), 211-226.
- Scarnati, J. T., & Scarnati, B. T. (2002). Empowerment: The key to quality. *The TQM Magazine*, 14(2), 110-119.
- Schein, E. H. (1993). On dialogue, culture, and organizational learning. *Organizational Dynamics*, 22(2), 40-51.
- Schein, E. H. (2004). *Organizational culture and leadership* (3rd ed.). San Francisco: Jossey-Bass.

- Schmidt, W. H., & Finnigan, J. P. (1993). *TQManager*. San Francisco: Jossey-Bass.
- Schneider, B. (1990). *Organizational climate and culture*. San Francisco: Jossey-Bass.
- Schneider, B., & Boweb, D. E. (1993). The service organization: Human resource management is crucial. *Organizational Dynamics*, 21(4), 39-52.
- Schultz, D., & Kitchen, P. (2000). A response to 'theoretical concept or management fashion?' *Journal of Advertising Research*, 40(5), 17-21.
- Schultz, D., Tannenbaum, S., & Lauterborn, R. (1996). *Integrated marketing communications: Putting it together and making it work*. IL: NTC Publishing Group.
- Schultz, D. E., & Kitchen, P. J. (1997). Integrated marketing communications in U.S. Advertising agencies: An exploratory study. *Journal of Advertising Research*, 37(5), 7-19.
- Schwandt, T. A. (1998). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (pp. 221-259). Thousand Oaks, CA: Sage.
- Scott-Morgan. (1994). *The unwritten rules of the game*. NY: McGraw-Hill.
- Scott, W. R. (1995). *Institutions and organizations*. Thousand Oaks, CA: Sage.
- Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (2nd ed.). New York: Teachers College Press.
- Senge, P. (1992). *The fifth discipline*. Sydney, NSW: Random House.
- Shannon, C. E., & Weaver, W. (1949). *The mathematical theory of communication*. Urbana, IL: University of Illinois.
- Sheaff, R. (2002). *Responsive healthcare: Marketing for a public service*. Buckingham, United Kingdom: Open University Press.
- Shimp, T. (1997). *Advertising, promotion, and supplemental aspects of integrated marketing communications*. FL: The Dryden Press.
- Shin, D., Kalinowski, J. G., & G.A., El-Enein. (1998). Critical implementation issues in total quality management. *Advance Management Journal*, 63(1), 10-14.
- Shortell, S. M., Bennett, C. L., & Byck, G. R. (1998). Assessing the impact of continuous quality improvement on clinical practice: What it will take to accelerate progress. *Milbank Quarterly*, 76(4), 593-624.

- Shortell, S. M., O'Brien, J. L., Carman, J. M., Foster, R. W., Hughes, E. F. X., Boerstler, H., et al. (1995). Assessing the impact of continuous quality improvement/total quality management: Concept versus implementation. *Health Service Research, 30*(2), 377-401.
- Shotter, J., & Gergen, K. J. (1994). Social construction: Knowledge, self, others, and the continuing conversation. In S. A. Deetz (Ed.), *Communication yearbook* (Vol. 17, pp. 3-33). Thousand Oaks, CA: Sage.
- Sigler, T. H., & Pearson, C. M. (2000). Creating an empowering culture: Examining the relationship between organizational culture and perceptions of empowerment. *Journal of Quality Management, 5*, 27-52.
- Silvester, J., Anderson, N. R., & Patterson, F. (1999). Organizational culture change: An inter-group attributional analysis. *Journal of Occupational and Organizational Psychology, 72*, 1-23.
- Simmerman, S. J. (1993). Achieving service quality improvements. *Quality Progress*, (November), 47-50.
- Sitakalin, P. (2003). *Maintaining quality service in Thai accredited hospitals in a climate of economic uncertainty*. Ph.D dissertation, University of Wollongong, NSW, Australia.
- Sitkin, S. B., Sutcliffe, K. M., & Schroeder, R. G. (1994). Distinguishing control from learning in total quality management: A contingency perspective. *Academy of Management Review, 19*, 537-563.
- Slater, S. F., & Narver, J. C. (1995). Market orientation and the learning organization. *Journal of Marketing, 59*(3), 63-75.
- Smircich, L. (1983a). Concepts of culture and organisational analysis. *Administrative Science Quarterly, 28*, 339-358.
- Smircich, L. (1983b). Implications for management theory. In L. L. Putnam & M. E. Pacanowsky (Eds.), *Communication and organizations: An interpretive approach*. (pp. 221-242). Beverly Hills, CA: Sage.
- Smircich, L. (1983c). Organizations as shared meanings. In L. R. Pondy, P. J. Frost, G. Morgan & T. Dandridge (Eds.), *Organizational symbolism* (pp. 55-65). Greenwich, CT: JAI Press.
- Smircich, L., & Calas, M.B. (1987). Organisational culture: A critical assessment. In F.M. Jablin, L.L. Putnam, K.H. Roberts & L.W. Porter (Eds.), *Handbook of Organisational Communications: An Interdisciplinary Perspective*. Sage Publications: London.
- Smircich, L., & Morgan, G. (1982). Leadership and the management of meaning. *Journal of Applied Behavioral Science, 18*, 257-273.
- Smircich, L., & Stubbart, C. (1985). Strategic management in an enacted world. *Academy of Management Review, 10*(4), 724-736.

- Spencer, B. A. (1994). Models of organization and total quality management: A comparison and critical evaluation. *The Academy of Management Review*, 19(3), 446-471.
- Spoor, J. R., & Kelly, J. R. (2004). The evolutionary significance of affect in groups: Communication and group bonding. *Group Processes & Intergroup Relations*, 7(4), 398-412.
- Sripanthanakun, N. (1990). *Factors affecting the success of quality control circle*. National Institution of Development Administration, Bangkok, Thailand: VA Press.
- Sriussadaporn-Charoenngam, N., & Jablin, F. M. (1999). An exploratory study of communication competence in Thai organizations. *The Journal of Business Communication*, 36(4), 382-418.
- Stohl, C. (1984). Quality circles and the quality of communication. *Transactions of the International Association of Quality Circles*, 6, 157-162.
- Stohl, C. (1995). *Organizational communication: Connectedness in action*. Thousand Oaks, CA: Sage.
- Strauss, A. (1994). *Continual permutations of action*. Cambridge, United Kingdom: Cambridge University Press.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage.
- Supachutikul, A. (1998). Development of the quality services of 8 hospitals in the Ministry of Public Health: The first step to TQM/CQI in hospitals. *Health System Institute Newsletter*, 12 (October), 1-10.
- Supachutikul, A. (1999). *Hospital accreditation: Lessons from Canada*. Bangkok, Thailand: Desire CRM.
- Supachutikul, A. (2004). Personal communication, October 4, 2004.
- Sutcliffe, K. M. (2001). Organizational environments and organizational information processing. In F. M. Jablin & L. L. Putnam (Eds.), *The new handbook of organizational communication: Advances in theory, research, and methods* (pp. 197-230). Thousand Oaks, CA: Sage.
- Swain, W. N. (2004). Perceptions of IMC after a decade of development: Who's at the wheel, and how can we measure success? *Journal of Advertising Research*, 44(1), 46-66.
- Sypher, B. D., Mckinley, M., Ventsam, S., & Valdeavellano, E. E. (2002). Fostering reproductive health through entertainment-education in the Peruvian Amazon: The social construction of Bienvenida Salud! *Communication Theory*, 12, 192-205.
- Taylor, J. R., & Van Every, E. J. (2000). *The emergent organization: Communication as site and surface*. Mahwah, NJ: Lawrence Erlbaum.

- Thomas, D. C., Ravlin, E. C., & Wallace, A. W. (1996). Effect of cultural diversity in work groups. *Research in the Sociology of Organisations*, 14, 1-33.
- Thomas, J. B., Clark, S. M., & Gioia, D. A. (1993). Strategic sensemaking and organizational performance: Linkages among scanning, interpretation, action, and outcomes. *Academy of Management Journal*, 36, 239-270.
- Thompson, J. D. (1967). *Organizations in action: Social science bases of administrative theory*. New York: McGraw-Hill.
- Thompson, K. R. (1998). Confronting the paradoxes in a total quality environment. *Organizational Dynamics*, 26(3), 62-74.
- Thompson, L., & Fine, G. A. (1999). Socially shared cognition, affect, and behavior: A review and integration. *Personality and Social Psychology Review*, 3(4), 278-302.
- Thorne, M. L. (2000). Cultural chameleons. *British Journal of Management*, 11, 325-339.
- Tompkins, P. K., & Cheney, G. (1985). Communication and unobtrusive control in contemporary organizations. In R. D. McPhee & P. K. Tomkins (Eds.), *Organizational communication: Traditional themes and new directions*. (pp. 179-210). Beverly Hills, CA: Sage.
- Tonnessen, T. (2005). Continuous innovation through company-wide employee participation. *The TQM Magazine*, 17(2), 195-207.
- Torraco, R. J. (1997). Theory-building research methods. In R. A. Swanson & E. F. I. Holton (Eds.), *Human resource development handbook: Linking research and practice* (pp. 114-137). San Francisco: Berrett-Koehler.
- Townsend, K. (2005). *Teams, control, cooperation and resistance in new workplaces*. Ph.D. dissertation, Griffith University, Queensland, Australia.
- Tracy, S. J. (2000). Becoming a character for commerce: Emotion labor, self-subordination, and discursive construction of identity in a total institution. *Management Communication Quarterly*, 14, 90-128.
- Tranfield, D., Rowe, A., Smart, P. K., Levene, R., Deasley, P., & Corley, J. (2005). Coordinating for service delivery in public-private partnership and private finance initiative construction projects: Early findings from an exploratory study. *Proceedings of The Institution of Mechanical Engineers, Part B: Journal of Engineering Manufacture*, 214(4), 165-175.
- Triandis, H. C. (1989). The self and social behaviour in differing cultural contexts. *Psychology Review*, 96(3), 506-520.
- Triandis, H. C. (1995). *Individualism and collectivism*. Oxford, United Kingdom: Westview Press, Inc.

- Troutt, M. D., Ponce de Leo, J. A., & Bateman, D. N. (1995). The interplay between quality improvement principles and the employee communication process. *Benchmarking for Quality Management and Technology*, 2(4), 51-60.
- Tsai, W. (2002). Social structure of coopetition within a multiunit organization: Coordination, competition, and intraorganizational knowledge sharing. *Organization Science*, 13(2), 179-190.
- Tukiainen, T. (2001). An agenda model of organizational communication. *Corporate Communication: An International Journal*, 6(1), 47-52.
- Tushman, M., & Nadler, D. (1978). Information processing as an integrating concept in organization design. *Academy of Management Review*, 3, 613-624.
- Vallacher, R. R., Nowak, A., & Zochowski, M. (2005). Dynamics of social coordination: The synchronization of internal states in close relationships. *Interaction Studies*, 6(1), 35-52.
- Van de Ven, A. H. (1976). On the nature, formation and maintenance of relations among organizations. *Academy of Management Review*, 1, 24-36.
- Van de Ven, A. H., Delbecq, A. L., & Koenig, R., Jr. (1976). Determinants of coordination modes within organizations. *American Sociological Review*, 41, 322-338.
- Van Maanen, J. (1979). Reclaiming qualitative methods for organizational research: A preface. *Administrative Science Quarterly*, 24(4), 520-526.
- Van Maanen, J. (1995). *Representation in ethnography*. Thousand Oaks, CA: Sage.
- Verschuren, P. J. M. (2003). Case study as a research strategy: Some ambiguities and opportunities. *International Journal of Social Research Methodology*, 6(2), 121-139.
- Waddington, D. (1994). Participant observation. In C. Cassell & G. Symon (Eds.), *Qualitative methods in organizational research* (pp. 107-122). London: Sage.
- Wageman, R. (1995). Intedependence and group effectiveness. *Administrative Science Quarterly*, 40, 145-180.
- Waldman, D. A. (1994). The contributions of total quality management to a theory of work performance. *Academy of Management Review*, 19(3), 510-536.
- Walsh, J. P., & Ungson, G. R. (1991). Organizational memory. *Academy of Management Review*, 16, 57-91.
- Waters, H., Saadah, F., & Pradhan, M. (2003). The impact of the 1997-98 East Asian economic crisis on health and health care in Indonesia. *Health Policy and Planning*, 18(2), 172-181.
- Weick, K. E. (1979). *The social psychology of organizing* (2nd ed.). Reading, MA: Addison-Wesley.

- Weick, K. E. (1990). Introduction: Cartographic myths in organizations. In A. S. Huff (Ed.), *Mapping strategic thoughts* (pp. 1-10). Chichester: Wiley.
- Weick, K. E. (1994). Organizational culture as a source of high reliability. In H. Tsoukas (Ed.), *New thinking in organizational behavior*. Oxford, United Kingdom: Butterworth-Heinemann.
- Weick, K. E. (1995). *Sensemaking in organizations*. Thousand Oaks, CA: Sage.
- Weick, K. E., & Roberts, K. H. (1993). Collective mind in organizations: Heedful interrelating on flight desks. *Administrative Science Quarterly*, 38(3), 357-381.
- Weiss, J. (1987). Pathways to co-operation among public agencies. *Journal of Policy Analysis and Management*, 7(1), 94-117.
- Wendt, R., & Fairhurst, G.T. (1994). Looking for the vision thing: The rhetoric of leadership in the 1992 presidential election. *Communication Quarterly*, 42(2), 180-190.
- Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structured methods*. London: Sage.
- Westphal, J. D., Gulati, R., & Shortell, S. M. (1997). Customization or conformity? An institutional and network perspective on the content and consequences of TQM adoption. *Administrative Science Quarterly*, 42(2), 366-394.
- Wibulpolprasert, S., Tangcharensathien, V., & Lertiendumrong, J. (1998, 23-25 March). *The economic crisis and responses by health sector in Thailand in 1997-1998*. Paper presented at the Regional Consultation on Health Implications of the Economic Crisis in the South-East Asia Region, Bangkok, Thailand.
- Wiersma, W. (1995). *Research methods in education: An introduction*. (6th ed.). Sydney: Allyn & Bacon.
- Wilkinson, A., Marchington, M., & Goodman, J. (1992). Total quality management and employee involvement. *Human Resource Management Journal*, 20(4), 1-20.
- Witmer, D.F. (1997). Communication and recovery: Structuration as an ontological approach to organizational culture. *Communication Monographs*, 64, 324-349.
- Woodilla, J. (1998). Workplace conversations: The text of organizing. In D. Grant, T. Keenoy & C. Osrick (Eds.), *Discourse + organization* (pp. 31-50). London: Sage.
- Wooldridge, B. R., & Minsky, B. D. (2002). The role of climate and socialisation in developing interfunctional coordination. *The Learning Organization*, 9(1), 29-38.
- World Health Organization. (2002). *Quality assurance in district health system: Report of an interregional consultation Bangkok, Thailand 30 October - 3 November 2000*. New Delhi, India: World Health Organization, Regional Office for South-East Asia.

- Yanow, D. (2000). Seeing organizational learning: A 'cultural_217? view. *Organization*, 7(2), 247-268.
- Yasin, M. M., & Alavi, J. (1999). An analysis approach to determining the competitive advantage of TQM in health care. *International Journal of Health Care Quality Assurance*, 12(1), 18-24.
- Yin, R. (2003). *Case study research: Design and methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Young, J., & Wilkinson, A. (1999). The state of total quality management: A review. *The International Journal of Human Resource Management*, 10(1), 137-161.
- Zabada, C., Rivers, P. A., & Munchus, G. (1998). Obstacles to the application of total quality management in health-care organizations. *Total Quality Management*, 9(1), 57-66.
- Zahay, D., Peltier, J., Schultz, D. E., & Griffin, A. (2004). The role of transactional versus relational data in IMC programs: Bringing customer data together. *Journal of Advertising Research*, 44(1), 3-19.
- Zbaracki, M. J. (1998). The rhetoric and reality of total quality management. *Administrative Science Quarterly*, 43, 602-636.
- Zorn, T. E., Page, D. J., & Cheney, G. (2000). Nuts about change: Multiple perspectives on changed-oriented communication in a public sector organization. *Management Communication Quarterly*, 13(4), 515-566.
- Zucker, L. G. (1977). The role of institutionalization in cultural persistence. *American Sociological Review*, 42, 726-743.

APPENDIX A:

Information Sheet for Research Participants*

Your experience and knowledge are invaluable.....

share it with us ☺

What is the study about?

It is an exploratory case study on Coordination, Communication and TQM. It attempts to explore how an accredited hospital (representing an organization that has successfully implemented the Total Quality Management program) communicates.

Why this study is needed?

This study will provide a better understanding of how an organisation that has successfully implemented TQM communicates.

Who involves in this study?

This study aims to draw evidences from two groups of participants who work in the front office and back office at the hospital. To make this study manageable, it is limited to internal communication concerning organizational communication about the hospital administration, not in communication concerning medical treatments.

Do you really have to participate?

Participation in this project is entirely voluntary. Additionally, participants can withdraw from the project at any stage without penalty. So, it absolutely your own choice!

* This information sheet was translated into Thai.

What are you expected to do?

You can share your thoughts and experience in 2 ways by joining an interview session (30-60 minutes) and/or completing a questionnaire survey (30-45 minutes).

How your identity and confidential information be protected?

Your participation is absolutely anonymous. No personal information will be disclosed without obtaining permission. All personal information of the participants will be kept confidential and will be destroyed on completion of the project.

How will the results be communicated?

An information sheet summarising the major findings from the research will be sent to participant when the study is complete upon requests. The complete report will be sent to the hospital.

If you have any enquires regarding this study, please contact the researcher:

Contact numbers:

Email: k.srismith@student.canberra.edu.au

Address: School of Professional Communication
University of Canberra, ACT 2601, Australia

APPENDIX B:

Consent Form*

A CONSENT FORM

For: A PhD study on *Coordination, Communication and Total Quality Management: An Exploratory Case Study in an Accredited Private Hospital in Thailand*

Researcher: Karinrat Srismith, a PhD student at the School of Professional Communication, University of Canberra, Australia

This study is conducted under the following conditions:

- ◆ The study has been reviewed and approved by the Committee for Ethics in Human Research, University of Canberra prior to the study.
- ◆ The aim of this research is to understand the effect of a Total Quality Management (TQM) program on communicative attitudes and practices.
- ◆ The participants will be expected to provide the information about their communication experience, especially in relation to the implementation of TQM activities.
- ◆ The duration of participation can be varied from 30 minutes to 60 minutes for each participant
- ◆ No procedures have been designed to modify the knowledge, thinking, attitudes, feelings and/or behaviour of the participants. No risks or discomfort will be caused by the project.
- ◆ The identity of participants will not be disclosed and the data collected will be securely stored and not disclosed in accordance with guidelines set out by the university.

* This information sheet was translated into Thai.

- ◆ The data associated with the project will be stored under lock and key at the university on completion of the project for a period of five years. Only the principal researcher has access to the information collected.
- ◆ An information sheet summarising the major findings from the research will be sent to each participant upon request when the study is completed. The full report will be made available at your organizational library and on its website.
- ◆ Participation in this study is absolutely voluntary. The participants have their right to withdraw their participation or avoid answering questions they do not wish to answer at any time during the research process.
- ◆ If the participants have any enquiries concerning the research, they should contact the researcher, Ms Karinrat Srismith. Her contact detail is as follows.

Telephone number:

Email: K.Srismith@student.canberra.edu.au

Address: School of Professional Communication, 9C26

University of Canberra, ACT, 2601 Australia

Please sign and return this form at the end of the research session.

I, _____ have read and understood the information provided. I fully understand the entire process of the project and acknowledge that the participation in the project is voluntary and I reserve the right to withdraw from the project at any time during the research process.

Participant's signature

Date

APPENDIX C: Questionnaire Survey Results

Section A: Satisfaction Index towards the Amount of Received Information

Information about...	Working Level			Working Section			TOTAL
	MNG	OPT	t-Value	Front	Back	t-Value	
A1: My performance in my job	21.13	20.07	1.4	20.34	20.48	-0.2	20.43
A2: what is expected from me in my job	21.67	22.32	-0.8	22.11	22.1	0	22.10
A3: Pay, benefits, and conditions	17.56	17.31	0.3	16.08	18.01	-2.0*	17.39
A4: Things that go wrong in my organization	16.88	16.34	0.6	16.21	16.67	-0.5	16.52
A5: Performance appraisal systems	17.21	17.37	-0.2	17.68	17.15	0.6	17.32
A6: How problems which I report in my job are dealt with	17.11	16.30	1.0	16.28	16.71	-0.5	16.57
A7: How decisions that affect my job are reached	15.85	15.16	0.8	14.54	15.79	-1.5	15.39
A8: Promotion opportunities	14.84	13.53	1.4	13.74	14.08	-0.4	13.97
A9: Staff development opportunities	18.68	18.40	0.3	18.65	18.43	0.2	18.50
A10: How my job contributes to the organization	19.02	18.41	0.7	18.58	18.63	-0.1	18.61
A11: Major management decisions	17.04	16.47	0.6	16.59	16.69	-0.1	16.66
A12: Important new service developments	18.49	19.06	-0.6	18.76	18.91	-0.2	18.86
A13: Improvements in services or how services are delivered	19.93	20.56	-0.7	20.07	20.48	-0.4	20.35
A14: The goals of the organization	22.02	22.43	-0.4	22.20	22.33	-0.1	22.29
A15: The total range of services offered by my organization	20.18	22.68	-1.9**	21.53	22.28	-0.7	22.05

* Significant at 0.05 level, **Significant at 0.1 level

Overall, both groups satisfied the most with the amount of information they received regarding '*the goal of the organization*', followed by '*what is expected from me in my job*' whereas the least satisfied items were '*promotion opportunities*' and '*how decisions that affect my job are reached*'. There is a different view between the front and the back office regarding information they received on '*pays, benefits, and conditions*'—the back office was more satisfied with the amount of information they received than the front office (statistically significant, $p < .05$).

Section B: Satisfaction Index towards the Amount of Information You Sent

Information about...	Working Level			Working Section			TOTAL
	MNG	OPT	t-Value	Front	Back	t-Value	
B1: Reporting what I am doing in my job	21.16	19.62	1.8**	20.17	20.13	0.1	20.14
B2: Reporting problems in my work	18.67	16.41	2.6*	17.09	17.22	-0.1	17.18
B3: Expressing my opinions about my job	20.13	17.72	2.7*	18.7	18.46	0.3	18.54
B4: Asking for information essential for my work	18.46	16.93	1.6	17.94	17.21	0.8	17.45
B5: Giving my opinions about the performance of my immediate manager	19.03	17.22	1.9**	18.2	17.66	0.5	17.83
B6: Requesting clearer work instructions	20.01	18.32	1.8**	18.44	19.11	-0.7	18.89
B7: Reporting mistakes or failures that occur in my work area	19.89	17.67	2.2**	18.07	18.59	-0.5	18.42

* Significant at 0.05 level, **Significant at 0.1 level

There was a similar view among all sub-groups regarding the respondents' satisfaction level on the amount of information they sent. Overall, respondents satisfied the most with information they sent regarding '*reporting what I am doing in my job*' and satisfied the least with information they sent regarding '*reporting problems in my work*'. Interestingly, within the working level, although both levels shared a similar view of the most and least satisfied statement items on information sent, the management level tended to rate their satisfaction higher than those in the operational level. This is especially for the information they sent on '*expressing my opinions about my job*' and '*reporting problems in my work*' (statistically significant, $p < .05$).

Section C1: Degree of Satisfaction towards People Sending Information to You

From...	Working Level			Working Section			TOTAL
	MNG	OPT	t-Value	Front	Back	t-Value	
C1: Staff who are accountable directly to me	4.66	5.00	-0.5	4.81	4.61	0.7	4.67
C2: Immediate work colleagues	5.01	4.74	1.7**	4.65	4.92	-1.7**	4.83
C3: Colleagues in other departments	4.18	4.20	1.1	4.03	4.27	-1.5	4.19
D4: People in other departments who provide services for my area	4.08	4.19	-0.7	4	4.23	-1.5	4.15
C5: Immediate line manager	5.13	4.86	1.6**	4.88	4.99	-0.6	4.95
C6: Senior managers from other departments	4.31	4.22	0.5	4.24	4.25	-0.1	4.25
C7: The hospital management people	4.47	4.50	-0.1	4.45	4.51	-0.3	4.49

* Significant at 0.05 level, **Significant at 0.1 level

(Mean: Extremely satisfy = 6.51-7.00, very satisfy = 5.51-6.50, satisfy = 4.51-5.50, somewhat satisfy = 3.51- 4.50, not satisfy = 2.51-3.50, not very satisfy = 1.51-2.50, Extremely not satisfy = 1.00-1.50)

Overall, the respondent rated their satisfaction level towards people sending information to them between ‘satisfy’ (mean 4.51-5.50) and ‘somewhat satisfy’ (mean 3.51-4.50). The respondents from all groups seemed to share a similar view on the highest and lowest satisfaction score towards people who sent information to them. According to the respondent, they placed the highest satisfaction on their ‘*immediate line manager*’ and the lowest satisfaction for ‘*people in other departments who provide services for my area*’. One interesting finding was that the operational staff were satisfied the most with a statement on ‘*staff who are accountable directly*’ in sending information to them despite the fact that, at their working level, not many staff have subordinates and, for those who have subordinates, they usually have very few staff.

Section C2: Degree of Satisfaction Towards People Taking Action on Information You Send

From...	Working Level			Working Section			TOTAL
	MNG	OPT	t- Value	Front	Back	t- Value	
C1: Staff who are accountable directly to me	4.62	5.00	-0.5	5.11	4.44	2.6*	4.63
C2: Immediate work colleagues	4.79	4.74	0.3	4.59	4.83	-1.5	4.76
C3: Colleagues in other departments	4.31	4.21	0.6	4.13	4.29	-0.9	4.24
D4: People in other departments who provide services for my area	4.12	4.28	-1.0	4.13	4.27	-0.8	4.22
C5: Immediate line manager	4.18	4.73	0.5	4.9	4.69	1.3	4.76
C6: Senior managers from other departments	4.15	4.25	-0.6	4.32	4.16	0.9	4.21
C7: The hospital management people	4.26	4.42	-0.9	4.45	4.33	0.6	4.37

* Significant at 0.05 level, **Significant at 0.1 level

(Mean: Extremely satisfy = 6.51-7.00, very satisfy = 5.51-6.50, satisfy = 4.51-5.50, somewhat satisfy = 3.51-4.50, not satisfy = 2.51-3.50, not very satisfy = 1.51-2.50, Extremely not satisfy = 1.00-1.50)

Overall, the respondent rated their satisfaction level towards people taking action upon information they sent between ‘satisfy’(mean 4.51-5.50) and ‘somewhat satisfy’ (mean 3.51-4.50). The respondents seemed to be satisfied with their ‘*immediate work colleagues and their immediate line manager*’ for the action they took upon the information the respondents sent, whereas staff from outside their working unit includes ‘*senior managers and people from other departments*’ received the least satisfaction score from the respondent. There was a slightly different view between the front and back office; the front office staff rated their satisfaction towards ‘*staff*

who are countable directly to them' in taking action upon the information they sent higher than respondents from the back office (statistically significant, $p < .05$).

Section D: How Quickly Do You Get Information From the Following Sources?

From...	Working Level			Working Section			TOTAL
	MNG	OPT	t-Value	Front	Back	t-Value	
D1: Staff who are accountable directly to me	3.69	3.33	0.9	3.81	3.62	1.3	3.68
D2: Immediate work colleagues	3.68	3.75	-0.8	3.67	3.75	-0.9	3.72
D3: Colleagues in other departments	3.29	3.25	0.3	3.28	3.26	0.2	3.26
D4: People in other departments who provide services for my area	3.19	3.42	-2.2*	3.38	3.32	0.6	3.34
D5: Immediate line manager	3.91	3.98	-0.7	4	3.94	0.6	3.96
D6: Senior managers from other departments	3.4	3.49	-1.0	3.51	3.44	0.7	3.46
D7: The hospital management people	3.69	3.73	-0.4	3.74	3.70	0.4	3.72
D8: The grapevine	3.18	3.34	-1.6**	3.33	3.27	0.5	3.29

* Significant at 0.05 level, **Significant at 0.1 level

(Mean: Always on time= 4.51-5.00, mostly on time= 3.51-4.50, Sometimes on time = 2.51-3.50, Rarely on time 1.51-2.50, Never on time= 1.00-1.50)

Overall, the respondent rate information received from various staff members between 'mostly on time' and 'sometimes on time'. Information received from 'immediate line manager' was rated the highest score with a mean of 3.96 reflecting a view of 'mostly on time', whereas, information received from 'colleagues in other departments' was rated the lowest score with a mean of 3.26 reflecting a view of 'sometimes on time'.

There were some statistic differences among the management and operation group. Although the mean of both groups reflected a view of 'sometimes on time', the operational staff tended to rate their score higher than the managerial staff for an item on information received from 'people in other department who provide service in my area' (statistically significant, $p < .05$) and for information received from 'the grapevine' (statistically significant, $p < .1$).

**Section E: Satisfaction Index You Have towards the Amount of Information
You Are Receiving Through These Channels**

From...	Working Level			Working Section			TOTAL
	MNG	OPT	t- Value	Front	Back	t- Value	
E1: Face-to-face contact between myself and my managers	19.79	18.34	2.0*	18.74	18.87	-0.2	18.83
E2: Face-to-face contact among people in my work area	23.05	22.63	0.4	21.53	23.36	-1.9**	22.78
E3: Telephone calls from my managers	19.85	17.44	2.5*	17.35	18.68	-1.4	18.26
E4: Written communications from my managers (memo, letters, etc)	18.79	18.21	0.6	17.66	18.76	-1.1	18.41
E5: Policy statements	21.29	21.51	-0.2	21.27	21.51	-0.2	21.43
E6: Notice boards	18.48	17.18	1.3	17.83	17.52	0.3	17.62
E7: Internal publications (magazines, newsletter, ect.)	16.38	17.31	-0.9	18.14	16.46	1.6	17.00
E8: Internal audio-visual (videos, films, slides, ect.)	14.63	15.61	-1.0	14.91	15.45	-0.5	15.28
E9: Intranet, emails, webboards	18.57	18.43	0.1	17.78	18.8	-0.8	18.47
E10: Small team meetings	18.18	18.60	-0.4	18.98	18.22	0.7	18.46
E11: Departmental meetings	21.34	20.96	0.3	21.63	20.84	0.7	21.09
E12: The grapevine (by random word of mouth)	10.53	12.60	-2.3*	11.60	12.04	-0.5	11.90

* Significant at 0.05 level, **Significant at 0.1 level

Overall, the respondent placed the highest satisfaction towards the amount of information they received from ‘Face-to-face contact among people in my work area’ whereas ‘the grapevine’ received the lowest satisfaction score. There was a different view between managerial and operational staff. The management tended to rate their satisfaction level higher than the operational staff (statistically significant, $p < .05$) regarding items on the amount of information they received from their superiors: ‘*face-to-face contact between myself and my managers*’ and ‘*telephone calls from my managers*’, whereas, the operational staff rated their satisfaction level higher than the management towards the amount of information they received from ‘*the grapevine*’ (statistically significant, $p < .05$).

Section F: Working Relationships

Statement	Working Level			Working Section			TOTAL
	MNG	OPT	t-Value	Front	Back	t-Value	
F1: I trust my co-workers	5.08	4.93	1.0	4.7	5.11	-2.9*	4.98
F2: My co-workers get along with each other	5.55	5.47	0.6	5.28	5.60	-2.4*	5.50
F3: I trust my immediate supervisor	5.73	5.74	-0.1	5.87	5.67	1.4	5.73
F4: My immediate supervisor is honest with me	5.41	5.38	0.2	5.49	5.34	0.8	5.39
F5: My immediate supervisor listen to my ideas	5.16	4.76	1.9**	4.56	5.06	-2.3*	4.90
F6: My immediate supervisor is friendly with his/her subordinates	5.14	4.92	1.1	5.07	4.96	0.5	4.99
F7: My immediate supervisor offers guidance for solving job related problems	5.24	5.09	0.9	5.33	5.06	1.4	5.14
F8: Our hospital has a competent management team	5.44	5.47	-0.2	5.51	5.43	0.5	5.46
F9: Top management is making efforts to communicate with employees	4.59	4.44	0.7	4.47	4.5	-0.2	4.49
F10: I usually have a say in decisions that affect my job	4.88	4.37	2.7*	4.57	4.53	0.2	4.54
F11: I have a part in accomplishing my organization's goals	5.55	5.21	2.2*	5.43	5.28	0.9	5.33

* Significant at 0.05 level, **Significant at 0.1 level

(Mean: Totally agree = 6.51-7.00, very agree =5.51-6.50. agree = 4.51-5.50, somewhat agree 3.51-4.50, not agree 2.51-3.50, not very agree =1.51-2.50, totally not agree = 1.00-1.50)

Overall, the respondents rated their agreement towards 11 statements ranging from 'very agree' to 'somewhat agree'. The item statement on '*I trust my immediate supervisor*' received the highest score with a mean of 5.73 reflecting an agreement of 'very agree', followed by '*my co-workers get along with each other*' and '*our hospital has a competent management team*' of which their mean indicated an agreement of 'agree'. The lowest score was for the statement item of '*top management is making efforts to communicate with employees*' indicating the agreement level of 'somewhat agree'. The back office tended to score higher than the front office on the statement '*I trust my co-workers*', '*my co-workers get along with each other*,' and '*my immediate supervisor listen to me*' (statistically significant, $p < .05$). The management tended to rate their satisfaction higher than the operation on a statement on participant decision making, '*I usually have a say in decisions than affect my job*' and on the statement of recognizing their contribution, '*I have a part in accomplishing my organization's goals*' (statistically significant, $p < .05$).

Section G: Satisfaction towards the Hospital Internal and External Communication

Communication direction	Working Level			Working Section			TOTAL
	MNG	OPT	t- Value	Front	Back	t- Value	
Internal communication	6.82	7.03	-0.9	6.95	6.96	0.0	6.96
<i>Horizontal communication</i>	6.39	6.62	-1.0	6.42	6.60	-0.8	6.54
G1: Communication within department	6.84	6.95	-0.5	6.92	6.91	0.0	6.91
G2: Communication between departments	5.95	6.28	-1.4	5.92	6.28	-1.6	6.17
<i>Vertical communication</i>	5.66	5.84	-0.7	5.6	5.86	-1.0	5.78
G3: Communication from operation staff to management staff	5.21	5.50	-1.1	5.48	5.37	0.4	5.40
G4: Communication from management staff to operational staff	6.12	6.18	-0.2	5.74	6.36	-2.4*	6.16
External communication	6.42	6.48	-0.2	6.20	6.58	-1.5	6.46
G5: Hospital communication in relation to providing information to customers	6.95	6.83	0.4	6.88	6.87	0.1	6.87
G6: Hospital communication in relation to building relationships with customers	7.03	7.08	-0.2	7.06	7.07	0.0	7.06
G7: Hospital communication in relations to creating its desired image	7.64	7.58	0.3	7.53	7.63	-0.4	7.60

* Significant at 0.05 level, **Significant at 0.1 level

Remark: Based on Likert scale from 1 (not at all satisfy) to 10 (extremely satisfy)

Overall the respondents seemed to be satisfied with the hospital's internal communication more than the hospital's external communication. However, the highest score was rated for an item on external communication of '*hospital communication in relations to creating its desired image*'. Within the internal communication, the respondents tended to be satisfied with 'Horizontal Communication' more than 'Vertical Communication' and, within the 'Horizontal Communication' section, the item regarding *communication within departments* received a satisfaction score higher than the item on *communication between departments*. As for the vertical communication, staff rated their satisfaction towards top-down communication higher than bottom up communication. There was no statistic difference between sub-groups apart from the statement on '*communication from management staff to operational staff*'. Staff from back office scored their satisfaction higher than those in the front office (statistically significant, $p < .05$).