

Multirational Management

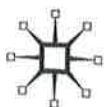
Mastering Conflicting Demands in a Pluralistic Environment

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4

Multirational Management in Hospitals

Harald Tuckermann

Sameness leaves us in peace, contradiction makes us productive. (J. W. von Goethe)

I argue in this chapter that multirational management means handling paradoxes. The core paradox is that the multirational or pluralist practice within hospitals requires, but at the same time thwarts, the genuine task of management. This task involves ensuring decision-making in a way that contributes to the viability of the organisation. Hospitals have developed their own ways of handling this paradox of “multirational management”. Two examples – one of bilateral-situative decision-making, the other of rule-based decision-making – will be elucidated in empirical detail.

4.1 The management of pluralist organisations – a paradoxical task

Hospitals are a prominent example of multirational or pluralist organisations. They are characterised by interaction between professions and disciplines. These professions and disciplines enjoy a historically grown and relatively high degree of autonomy. Their autonomy results from the knowledge-intensive work of increasingly specialised experts. In line with their profession or discipline, the experts have developed their own understanding of the organisation and their own organising practice (Denis et al. 2001; Glouberman and Mintzberg 2001a, 2001b).

The *management* of a hospital is a demanding function of the organisation. The core value creation of management consists in ensuring decision-making with a view to the viability of the organisation as a whole (Wimmer 2004). Management is responsible for establishing,

maintaining and developing the prerequisites and practices for decision-making in the organisation. Particularly in pluralist organisations, decisions are – first – distributed throughout the organisation (Bower and Gilbert 2007). Second, decision-making is a collective, communicative process (Luhmann 2000; Denis et al. 2001), not an individual affair. Decision-making is a process that takes place between individuals who contribute to decisions in order to achieve organisational “commitments to act” (Langley et al. 1995). As per this definition, management decisions take into account the hospital as a whole and the diversity of professions and disciplines. But the diversity of professions and disciplines turns (rational) decision-making into an impossible task. Decisions cannot be unequivocally and objectively calculated in a rational manner because the diversity of perspectives prohibits uncontroversial decision-making criteria and comparable alternatives. Therefore, decisions become necessary because issues are (rationally) undecidable (von Foerster 1994).

This article builds on the premise that management in the multirational context of a hospital is a paradoxical task. Owing to the wide variety of perspectives, understandings, interests of the different professions and disciplines, it is becoming increasingly important, and at the same time difficult, to ensure decision-making. This paradox manifests itself particularly in organisation-wide decisions which span departments and have a bearing on issues like strategy, organisation, co-operation or management itself. The increasing demand for such organisation-wide decisions is the topic of the first section, in which I focus on the Swiss context. The second section contains the formulation of the paradox of “multirational management” through an outline of decision-making practices of different disciplines. Subsequently, “bilateral-situative decision-making” and “regulated decision-making in a system context” will provide two examples of how hospitals handle this paradox. The conclusion will contain a summary.

4.2 Starting point: an increasing need for decisions

As a consequence of today's changes, hospitals increasingly need to address *decision-making necessities* that exceed the historically grown boundaries of the relatively autonomous professions, clinics and departments (Tuckermann and Rüegg-Stürm 2012). In Switzerland for example, such necessities include questions of the strategic positioning of a hospital as a whole, its embeddedness in the local environment and, in particular, its relation with referring doctors, the reintegration of the hospital's own patient treatment, the assurance of financial survival in

the course of the introduction of DRGs and the sustainable recruitment, development and retention of suitable personnel. Such issues require *cross-departmental decisions*.

The introduction of DRGs (diagnosis related groups) in Switzerland with the expected concomitant lifting of cantonal borders will give rise to more organisation-wide questions. In contrast to the previous funding mechanism, which was fundamentally geared to the services provided, DRGs assign a basically standardised overall monetary value for a certain diagnosis. Thus DRGs cap the resources available for a case of treatment, which highlights the efficient use of resources. Owing to specialisation in medicine, the allocation of (scarce) resources is becoming increasingly cross-departmental because patient treatment spans departments and departments make use of shared infrastructural resources. Therefore, DRGs call for more organisation-wide decisions. The same effect results from the lifting of cantonal borders. This lifting provides hospitals with a larger catchment area of potential patients and with more competition than before, when hospitals enjoyed regional protection. In general, enhanced competition requires hospitals to define their strategic positioning, expressed in a selected range of services profiled to appeal to patients and referring doctors. Defining this range of services, in turn, requires a selection and choice of certain types of medical care and services over others. Therefore we expect a rise in organisation-wide decisions hospitals need to address.

Besides these exogenous developments, organisation-wide decisions also result endogenously. Within hospitals, the functionally necessary specialisation results in a stronger demand for reintegration between professions and disciplines. After all, patients' ailments cannot always simply be divided up among disciplines. The chief executive of a large cantonal hospital illustrates the increase in specialisation by pointing out that a hospital patient was looked after by three to five professionals about 40 years ago, whereas today he estimates that the number is between 15 and 20 professionals, often from different disciplines. These estimates indicate that the internal demand for co-ordination and decision-making between professions, disciplines, clinics and departments has markedly increased. The effect of the DRGs outlined above exacerbates the demand for co-ordination among professions and disciplines because the dimension of scarce resources enters decision-making processes that are otherwise based on treatment aspects. Thus, organisation-wide decisions result from the operative daily work of treating patients.

The increase in organisation-wide decisions clashes with a historically grown decision-making practice of hospital organisations which

primarily took its bearings from the various professions and disciplines and which will be illustrated in the following section with the help of four examples. The diversity of decision-making practices result in a demand for analytical and communicative integration that turns multi-rational management into a paradox.

4.3 Many-faceted decision-making practices and the paradox of "multirational management"

It is primarily the specialisation that started in the 19th century and has grown faster since the Second World War that has brought forth a great number of different disciplines which, depending on the size of a hospital, are also represented within the organisation. Today, Switzerland has 45 professional associations which carry out their specific medical and nursing functions in the treatment of patients. These associations have developed their own respective decision-making practices in line with their specialised tasks. We observed (Tuckermann et al. 2012; Tuckermann and Rüegg-Stürm 2012) that these treatment decision-making practices are also applied to organisational issues. Within the departments, this transposition ensures stability since the decision-making practice in question can be assumed to be valid and legitimated by the discipline. In organisation-wide decision-making, however, these different decision-making practices clash, which leads to the paradox of "multirational management". Before we formulate this paradox, we describe different types of decision-making practice.

We can broadly depict the differences between the decision-making practices of surgeons, internists, carers and administrators by comparing them alongside the question of "Who decides what, when and how?"

Surgical decisions are geared to speed, thus tend to be made by individuals and, if required, involve rapid follow-up work on possible side effects after an intervention or action. Accordingly, the focus of what is part of the decision-making problem is narrowed down to the priority problem, both in the operating theatre and in connection with organisational issues. Surgical decisions correspond to originary treatment practice that is focused on demanding invasive interventions, is urgent and depends on the operator's individual technical skills.

Internists' decision-making is comparatively slower, with the explicit involvement of colleagues with whom ideally a consensus is reached. The course of action takes its bearings from a core of their medical activities, that is making a diagnosis. Against the background of diverse symptoms that may change over time, internists must recognise patterns in

Table 4.1 Decision-making practice of different professions

	Administration	Surgery	Care	Internal medicine
How?	Formalised, report-oriented procedure	Action and follow-up	Predefinition of the task and involvement of the basis for concrete implementation	Continuous investigation (waiting) and activity when the time is ripe
Who?	Project team/agent; continual formalisation by executive board	Individual (senior consultant) (possibly after consultation with directly subordinated staff)	Care management down to ward staff with different tasks	Senior doctors (group), preferably in a consensus with colleagues who might be affected
What?	Question of a department	Concrete problem	Question and social context (atmosphere, interfaces)	Question and effects on affected departments
When?	By assignment, according to planned schedule	Ad hoc, fast re(action) when required	By assignment, according to planned schedule and developing process upon implementation	According to developing issues, response to occasions

consensual consultation and condense them into certain hypotheses. It can be observed that the internists treat organisational issues in an analogous manner (Tuckermann et al. 2012). In this decision-making practice, the focus of what is part of the decision-making situation is often comparatively wider and includes the temporal dimension and the perspective of people potentially affected by organisational issues.

Besides the focus of internal medicine, decisions in *care* primarily also contain the relational dimension between the people involved, which mirrors a core of nursing activities (Tuckermann 2007). Consequently, decisions and development efforts for organisational questions include involving a broad range of the different hierarchical rungs. From the middle part of the hierarchy upwards, nursing staff increasingly or exclusively fulfil management functions. Decision-making processes are supported with management instruments. This goes hand in hand with a continual integration of the ward teams with whom concrete implementability is developed and a positive ward atmosphere is aspired to.

In comparison with the medical and nursing professions, decisions in the so-called *administration* are more difficult to describe. At present, this function is undergoing a fundamental transition from a traditionally rather bureaucratic to a more management-oriented decision-making practice. At the same time, the administration is under particular pressure to justify itself vis-à-vis the doctors. Traditionally, hospital administrations have made their decisions more in accordance with a bureaucratic model in which the focus has been on compliance with formalised procedures. For example, a member of staff describes the management of interdisciplinary projects as a sequence of preliminary, intermediate and final reports for the attention of the executive board. Decisions are planned correspondingly sequentially in advance and preferably made, implemented and finally checked by the executive board.

The different decision-making practices rudimentarily outlined here correspond to the groups' respective treatment practices – with the exception of the administration. This correspondence between decision-making in-patient treatment and organisational issues explains why every department tends to regard its own decision-making practice as appropriate and as taken for granted. This taken-for-grantedness ensures stability within the departments, which is of crucial significance for their value creation (Tuckermann and Rüegg-Stürm 2007). At the same time, the decision-making practices illustrate the diversity against whose background hospitals can be characterised as “multirational” or “pluralistic”. Besides different interests and perspectives (Denis et al. 2001; Glouberman and Mintzberg 2001a, 2001b; Lozeau et al. 2002; Denis et al. 2007), the

practice of decision-making differs between departments. Beyond issues like that of different power constellations, mutual incomprehension or the autonomy of the different actors (Bate 2000; Ericson 2001; Lozeau et al. 2002), managing the different practices of decision-making turns out to be a core challenge for management. Management means integrating this plurality, particularly in the context of organisation-wide decisions. At the same time, it is precisely this plurality which aggravates integration. “Multirational management” thus turns into an operative paradox (Ortmann 2004), an operation which simultaneously generates the conditions of its possibility and impossibility. Figure 4.1 outlines the paradox of “multirational management”.

How can management handle this paradox? Research on paradoxes in organisations (Putnam 1986; Poole and van de Ven 1989; Lewis 2000; Clegg et al. 2002; Luscher and Lewis 2008; Smith and Lewis 2011) fundamentally points out two variants. So-called “either...or” solutions imply choosing one or the other side of a paradox – that is, either diversity or integration. Most often, however, such a choice is considered to worsen the tension between the poles of the paradox. Therefore, the literature has favoured “both...and” solutions owing to the perception that both sides of the paradox are necessary for the organisation. The focus is less on the sides or poles of the paradox and more on their relationship (Clegg et al. 2002). The more recent systems theory (von Kibéd and Sparrer 2003) offers a third starting point, which can be traced back to Indian logic (Ganeri 2004). The so-called “neither...nor” option focuses on the context in which the paradox is embedded and which, vice versa, it reproduces.

The three variants constitute ways of dealing with a paradox, each with its own focus. Hospitals have developed their own ways of dealing with the paradox of “multirational management” over time. Necessarily

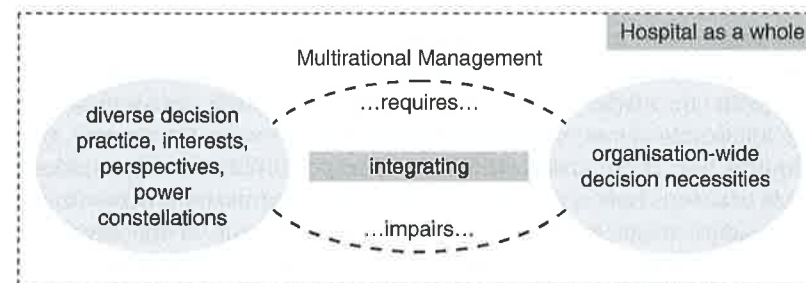


Figure 4.1 Multirational management as a paradox

abstract when expressed in theoretical terms, two of these will be presented below. They illustrate the "both ... and" and the "neither ... nor" variants.¹

4.4 "Both ... and": bilateral-situative decision-making

Over time, a practice has evolved in Swiss hospitals for handling the differences between relatively autonomous actors in the context of organisation-wide decisions. Characteristic for this decision-making practice are bilateral arrangements and the situative treatment of pending questions. Correspondingly, we call it "bilateral-situative decision-making". Bilateral-situative decision-making illustrates how both diversity and organisation-wide decisions can be dealt with and how in this way, the paradox of "multirational management" can be handled in a "both ... and" way that leaves each side of the paradox intact.

The core of this decision-making practice is the autonomy of the professional fields. A member of the executive board of a cantonal hospital defines this way of thinking as follows: "Everyone cultivates their own garden: the internists, the surgeons. The administration primarily thinks of money, which I suppose is correct and all the rest of it. It is an executive board which ultimately is more likely to represent particular interests."

On the one hand, this autonomy reflects the functional specialisation in which representatives of different fields are less and less able to influence each other. In this way, this autonomy is also expressive of the development of knowledge in the last few centuries, which has led to the progress of modern medicine. Moreover, the "cultivation of individual gardens" helps actors to stabilise their everyday work which, with the diagnosis and therapy of patients, is characterised by fundamental uncertainty (Tuckermann and Rüegg-Stürm 2007).

On the other hand, and with a look at the organisation as a whole, this first entails that decision-making is increasingly spread throughout the organisation. It therefore tends to be less clear where and by whom decisions are made. This is particularly true of those decisions which are applicable across various garden fences, as it were. Conversely, this requires that those actors who assume responsibility for organisation-wide decisions have a good (over)view of the organisation. Accordingly, a president of an executive board describes the role of the executive board as a "sounding board" into which topics are introduced but which also filters out the topics that are currently being worked on in the organisation.

Second, the "cultivation of individual gardens" and the autonomy it expresses entails that decisions at the level of the hospital as a whole are relatively difficult to make vis-à-vis those actors whom they affect. In this context, Denis et al. (2001) aptly state that the leadership of a top management depends on the consent of those who are led. Similarly, a member of the executive board of a cantonal hospital describes a great aspiration to harmony: "The need for harmony is great. People try to reach a consensus. One area tries to interfere as little as possible with the others." This pursuit of harmony contributes to the stabilisation of the organisation as a whole but also entails that possible conflicts and differences are moved out of the way and deferred. Conflict-laden situations, in particular, are handled in bilateral meetings between individual clinics, fields and institutes rather than in the public glare of a body such as the executive board. Individual meetings are comparatively simpler to conduct and pave the way for an agreement or a decision between two parties in the first place. By contrast, larger groups such as an executive board can hardly be controlled owing to their diverse interests, mutual obligations and interdependencies. Bilateralism facilitates decision-making with regard to individual issues, sometimes even at high speed. In addition, it does not question the autonomy of the different disciplines.

Third, and in interaction with the autonomy of the various decision-making practices, organisation-wide decision-making becomes a continual movement which can only be structured to a very limited extent. Everything seems to be in a process, as a hospital CEO explains: "The clinics tend to do their own thing... The way we're interlinked and if the clinics continue to be independent... Everything is run by informal networks anyway, everyone knows everyone else. ... This requires a lot of flexibility."

Fourth, when it comes to bilateral-situative decision-making, the agenda-setting tends to be bottom-up rather than top-down. In this context, it is difficult to determine which issues and questions are central for the hospital as a whole and must be worked on in terms of a decision. The agenda is set in a decentralised way: "The impulses must come from the unit, you can't impose it from above" (executive board member). One consequence of this is the tendency to table more department-specific issues, which means that fewer organisation-wide decisions are dealt with. Another consequence may be that bilateral-situative decision-making turns into a self-reinforcing cycle that leads to more ambiguity than before. In particular, those issues that may provoke disagreement and that are pending tend to be addressed through bilateral-situative

arrangements that in turn produce uncertainty and ambiguity for all of those excluded who, in turn, may use bilateral-situative arrangements to handle their perceived uncertainty and ambiguity. A third consequence is that bilateral-situative decision-making may lead to delayed decisions, particularly since it is precisely decisions at the level of the organisation as a whole that require a great number of different bilateral clarifications. An executive board member describes this as follows: "At the preliminary stage, I've got to speak to everyone in private. I just mustn't talk to all of them together, that would provoke a unanimous 'no'... After this preparation work, we then have a meeting together."

Fifth, bilateral-situative decision-making may tend to prefer possibilities that give reason to expect less contradiction even though this choice sometimes contributes less to the further development of the organisation as a whole. Decisions with a higher conflict potential tempt actors to push them aside. Thus a decision concerning investments is postponed, or the demarcation of an outsourced new interdisciplinary centre is delegated to the operative level. In the first instance, people wait for resources to be allocated to them, while in the second instance, people are held up by disputes over competencies which basically cannot be dealt with at their level of daily patient treatment. This means that some decisions are deferred, dealt with in sub-optimal places or dealt with only in part. This particularly applies to cross-departmental decisions because there is little clarity about the way in which decisions are made and because, as mentioned earlier, "everything is run by informal networks anyway".

Despite the challenges outlined above, the crucial achievement of "bilateral-situative decision-making" is the stabilisation of the organisation as a whole with the simultaneous acknowledgement of a relatively high degree of autonomy and the concomitant spread of decision-making. At the same time, "bilateral-situative decision-making" is contingent on the existence of some preconditions: with a view to the organisation as a whole, bilateral-situative decision-making requires sufficient financial, human and time resources. After all, organisation-wide decisions, in particular, involve lengthy harmonisation processes.

Managers or those authorities which promote and work on organisation-wide decisions succeed in making bilateral-situative decisions if, first, they are intimately familiar with the informal networks in the organisation and are aware of the different interests and interdependencies. Second, they themselves require a sympathetic reputation to ensure that departments accord them a sufficient amount of leeway.

The head of a clinic said about the hospital CEO: "With him you know that he doesn't want to harm anyone."

In practical management, a hospital CEO pools three essential instruments of managing that are necessary to ensure that decisions are made:

- *control of the really scarce resources* such as rooms and personnel, which means that in clinics, too, personnel decisions from a certain hierarchical level upwards are approved by the office of the hospital CEO;
- *control of formal communication*, particularly at executive board level, concerning agenda-setting and the preparation and approval of the minutes of every meeting;
- *continuous presence in the organisation* by means of "management by walking around" the various departments and hierarchical levels. This provides the CEO with knowledge about current issues in the organisation and at the same time strengthens his reputation by enabling him to explain pending or recent decisions in a personal conversation.

Bilateral-situative decision-making has evolved as a possibility which allows for both diversity and organisation-wide decisions. Bilateral-situative decision-making thus constitutes a possibility of dealing with the paradox of "multirational management". Figure 4.2 represents this connection graphically.

At the same time, however, bilateral-situative decision-making rests on preconditions which are increasingly being eroded. The relative scarcity of resources raises the necessity for decisions within hospitals. These decision necessities increasingly also concern questions about parting company with, or halting the development of, certain fields of activity, which again is aggravated by bilateral-situative decision-making.



Figure 4.2 Bilateral-situative decision-making

4.5 “Neither...nor”: regulated decision-making in a system context

As the relative scarcity of resources is on the increase, an additional variant of dealing with the paradox of “multirational management” is evolving. Its essential difference from bilateral-situative decision-making consists in a differently chosen starting point. Bilateral-situative decision-making takes over the context of a hospital as a whole through accepting the different actors’ autonomy. The approach I will describe in the subsequent section draws a distinction between the treatment and the system context when it comes to organisation-wide decision-making. The treatment context regards decisions on patient treatment and allows for professional autonomy. The system context comprises all decisions that ensure the preconditions of the professionals’ patient treatment. Here, multirational management occurs in a regulated decision-making process, which is why this type of decision-making is called “regulated decision-making in a system context”.

The cornerstone of this decision-making practice is the differentiation between treatment and system context (Rüegg-Stürm 2008). The treatment context extends to all treatment decisions, which are usually made in the interaction between doctors, nurses and therapists with regard to certain patients. In terms of time, these decisions are related to concrete situations in the present. At the same time, and in a future-oriented way, the treatment context also includes the development of individual disciplines and professions in terms of research and training, which is accorded a great deal of value in clinics, institutes and departments.

The system context designates the area of prerequisites required for successful treatment work in a hospital. These prerequisites include questions of co-operation between clinics, departments and institutes with regard to continuing everyday work in the hospital and thus to the overarching patient processes. Added to this, there is the continual provision of the resources required for treatment work, such as personnel and funds, but increasingly also information and data flows. Furthermore, the system context contains the clarification of who decides on what, when and in which way. This present-oriented dimension is combined with a future-oriented one, which predominantly draws on strategic issues. This is about the future orientation of the hospital as a whole in the context of other providers, about co-operation with other service providers, about the configuration of relationships with referring doctors or about their embeddedness in the local environment. A summary of

the differences between the treatment and system contexts is represented in Figure 4.3.

“Regulated decision-making in a system context” combines the two interwoven areas of process optimisation and strategy work. Process optimisation (Merz et al. 2008) primarily refers to the stabilisation of present everyday work for selected treatment processes that are typical of a hospital. A highly detailed record of how selected patient processes take place in everyday life, it becomes recognisable to everyone who is involved in the activities and how these activities are interconnected. The co-ordination issues that come to light in this process of reflecting one’s own work help actors to question what was previously taken for granted, thus enabling potential change. Changes are geared to the jointly ascertained patient process, which constitutes an alternative decision-making horizon. If done collectively by those involved, the patient process that overarches the disciplines and professions can become a shared point of reference. This point of reference changes the context in which the paradox of “multirational management” manifests itself in everyday working life. In my experience, when the practitioners reflect on their daily work in this way, they often raise the question of who decides what and when. In other words, this form of process

	Treatment context	System context
	Treatment development	Hospital development
Future	Treatment development, research, training and education	Strategising: stabilisation of the hospital's future
Present	Interaction between doctors, nurses, therapists: situative mobilisation of expertise	Process optimisation: stabilisation of daily work
	Patient treatment	Operating wards

Figure 4.3 Treatment and system context

optimisation makes it possible to thematise management with reference to everyday work. It allows reflection on the often organically grown decision-making practices from the angle of a shared point of reference, that is the patient process.

For such a joint reflection on daily work and for the development of a shared alternative reference, the following preconditions are necessary:

- a project structure of its own which handles the demand for decisions generated or represented by process optimisation in a systematically transparent and comprehensible manner;
- a sustainable commitment on the part of the hospital, clinic and department executives because such an initiative is frequently connected with the clarification of tasks, competencies and responsibilities of offices and bodies, to make sure that any changes that arise are comprehensible and fair;
- continual communicative embedding of project work into current operations in order to demonstrate the benefit of such an initiative;
- prevention of overloading the organisation with continuing initiatives and other projects, which often run in parallel because a quality certification is pending, because DRGs have just been introduced, etc.

Such process optimisation often leads to fundamental questions concerning the management architecture in a hospital, that is the make-up of the communicative wiring between the various bodies such as hospital, department, clinic, field and ward executives. This, in turn, raises questions about which body and which office takes which decisions.

The second constituent of "regulated decision-making in a system context" (for details, cf. Rüegg-Stürm and Bachmann 2012) is strategy work. At a micro-level, strategy work includes a structured problem-solving behaviour. In my example of a cantonal hospital, the core is a decision-making heuristic for management problems (Rüegg-Stürm and Bachmann 2012: 131–132) to ensure that decisions are made on the basis of a structured analysis, a generation of options and a narrowly defined proposal in which three variant solutions are formulated. This micro-structuring enables actors to reach decisions concerning submitted projects in a standardised, transparent and comprehensible manner.

At a more macro-level, strategy work includes continual self-observation and planning in a multi-annual rhythm. Whereas the strategic orientation is fundamentally developed every three years, it is

annually reviewed, adapted and refocused for three to six annual targets. A hospital CEO describes the annual cycle:

April is roughly the month for a SWOT analysis... May is for an evaluation of the analysis but also for the formulation of alternatives, programmes, projects where we say: "Next year we want to..." We have the strategy meeting in early July... This is where we fix our objectives. Then the hospital as a whole is informed.

Whereas benchmarks are developed in the course of the summer, next year's annual targets are reflected in the budget negotiations in the autumn and are then specified as every individual's contribution in performance reviews. The hospital CEO explains: "Each member of staff must be able to answer the question, 'What is my contribution to the target?'"

The temporal structuring aims to generate an expectable structure in the organisation in terms of when, how and by whom the objectives of the organisation as a whole are determined. Its individual steps require continuing communicative embedding to ensure that the individual objectives are comprehensible in the organisation and are harmonised on as broad a basis as possible.

When it comes to major development initiatives within, but also between departments, regulated decision-making in a system context requires a defined management of the different initiatives. For this purpose, a body in this hospital assesses the status of individual initiatives on a case-to-case basis, examines their contribution to the goals of the organisation as a whole, the demands they make on resources and their dependence on other ongoing developments in the hospital.

A further essential condition for success lies in the systematic establishment of a management architecture, that is the definition of tasks, competencies and responsibilities of the various bodies, as well as their interlinkage. Precisely because the distinction between treatment and system context with simultaneous process optimisation often suggests a matrix structure for the organisation, this clarification is exacting.

Above and beyond this, regulated decision-making in a system context frequently leads to an increase in perceived decision-making necessities, which initially concern the executive board. As a hospital CEO puts it: "If you work in that structured way and make all the decisions like this, then there are a great number of decisions. This overburdens the executive board, and this is why we have delegated many decisions to the lower levels, into the departments, clinics and wards." Conversely, this

delegation of decisions also reveals that "regulated decision-making in a system context" produces degrees of freedom in departments, clinics and wards which go hand in hand with a corresponding degree of responsibility for their own concerns. In addition, the aim is preferably to make decisions where the necessary expertise is in place (Rüegg-Stürm and Bachmann 2012: 137).

Besides the delegation of decisions, regulated decision-making in a system context ensures that decision-making processes are accelerated, that the readiness for change and development in the hospital is enhanced owing to the expectable and comprehensible decision-making processes and the decision-making processes become more predictable for all those involved.

However, there are at least three challenges to this mode of decision-making in a hospital. First, this pattern implies – at least partially and first of all – a limitation of the historically developed decision-making autonomy that the treatment context requires to be able to work. This frequently leads to challenges in the development of this decision-making pattern. Accordingly, a hospital CEO points out that a generally acknowledged necessity, for instance in the form of a crisis or organisational restructuring, is required. Second, a fundamental challenge consists in the recruitment of appropriate personnel, also for executive posts. Particularly among doctors, the focus is still on treatment work, whereas the system context has traditionally been dismissed as "admin work" (Rüegg-Stürm and Tuckermann 2008). Third, the development of "regulated decision-making in a system context" requires actors to further develop their own decision-making practices in the course of making decisions. Decisions basically contain two levels of impact: directly, decisions are about working on a pending question or problem; indirectly, the way in which these decisions are worked on today will also have an effect on the way that future decisions are made. Both effects are interwoven, which means that decision-making both works on a certain problem and helps create the way in which decisions will be made in the future. When actors further develop their decision-making practice while making decisions, they have to make the immediate decision while at the same time also deciding who will decide what, when and how. Keeping an eye on this double effect and working on it through decision-making is something which, in turn, makes the development of individual decision-making practices a paradoxical task (Rüegg-Stürm and Bachmann 2012; Tuckermann and Rüegg-Stürm 2012). Because of this paradoxical task, a fourth helpful condition is that the involved actors develop a shared understanding of management as such. As this

paper suggests at the beginning, hospitals, in particular, traditionally harbour very different ways of approaching organisational issues and decisions, depending on the professional specialisation.

"Regulated decision-making in a system context" illustrates the "neither...nor" variant by making a distinction between the treatment and the system context to deal with the paradox of multirational management. Furthermore, it starts out from the context in which the paradox of multirational management is integrated. In terms of time, it is then a question of process optimisation and strategy work. Figure 4.4 outlines regulated decision-making in a system context.

An essential achievement of regulated decision-making in a system context consists in ensuring organisation-wide decisions in the light of the looming relative scarcity of resources. At the same time, however, a development along these lines entails the risk of a fundamental destabilisation of the organisation since the distinction between the two contexts implies a limitation of the historically grown autonomy of clinics and departments, on the one hand. On the other hand, decision-making is becoming more complex because the question constantly arises as to which context a pending decision is part of. Until the above-mentioned clarification of the question as to who decides what, when and how has been stabilised, regulated decision-making requires a cooperative relationship between those involved and a workable communicative configuration of the development process. This is of great importance, in particular, because the development of individual decision-making practices takes place "with the engine running", as it were, that is while decisions about pending issues are continually being made.

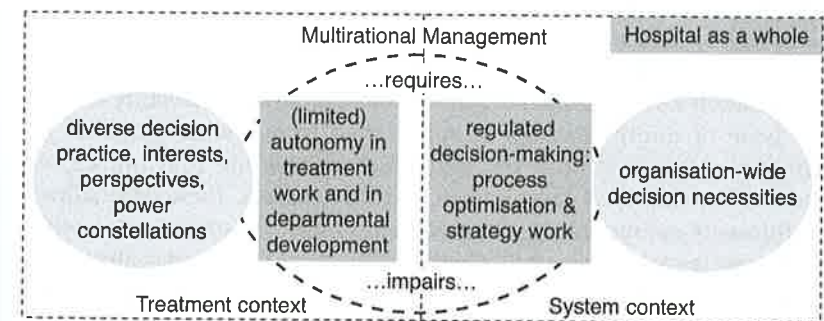


Figure 4.4 Regulated decision-making in a system context

4.6 Conclusion: development "with the engine running"

This chapter advocates the basic idea of understanding "multirational management" as a paradox. Hospitals, in particular, are increasingly facing decision-making necessities which concern the organisation as a whole. At the same time, their decision-making practices have been moulded by the professions and disciplines owing to their functions in-patient treatment. Because these many-faceted decision-making practices are applied to organisational questions and go beyond different interests, perspectives and power structures, the paradox of "multirational management" arises: diversity requires and impairs organisation-wide decisions. Specifically, "multirational management" in hospitals is about coordinating or integrating decision-making along three dimensions. In a hospital, organisation-wide decision-making becomes a complex management task which

- has to deal with different speeds and rhythms in a *temporal dimension*;
- is confronted by different foci and interests in a *factual dimension*. Particularly in hospitals, the organisation as a whole does not appear to be the "survival unit" as a signpost for decision-making; rather, individual clinics, departments and wards, or indeed individuals themselves, seem to have priority;
- is involved in participation in decision-making to varying extents in a *social dimension*, i.e. more collectively or more individually, more at the top of a hierarchy or on the side of competence (cf. nursing), etc.

Organisation-wide decisions, that is cross-departmental decisions and decisions which concern the originary issues of organisation, co-operation and management, are highly fragile and complex undertakings in pluralist organisations. This is the case, in particular, if an organisation has precisely not gone in for a dominant rationality. Often, the issue of multirationality is approached from the direction of its components, that is from the individual rationalities that impact on decision-making in an organisation. Within hospitals, these rationalities traditionally enjoy a certain degree of autonomy. For organisation-wide decisions, it cannot be established exactly how these rationalities are related to each other, that is what structures constitute their co-operation, opposition and mutual support as a dynamism of its own which emerges outside any individual rationalism, but between these rationalities. This

"in-between" aspect is what multirational management is about. To illustrate this, this chapter described two possibilities, namely bilateral-situative decision-making and regulated decision-making in a system context. These are a "both...and" and a "neither...nor" variant, respectively, applied to deal with the paradox of "multirational management". Each variant has its own preconditions, its own impact potential and its own limits. Consequently, they both serve as a source of inspiration for the development of context-specific ways of dealing with the paradox of "multirational management". Ultimately, this is about further developing individual decision-making practices while making decisions "with the engine running".

Note

1. Possibilities in connection with an "either...or", which refers to the dominance of one of the two poles, will not be considered here. Thus hospitals can traditionally conceive of themselves as primarily medical organisations which are not exposed to a relative scarcity of resources, or they can opt for the other pole, like some private hospitals with in-patient doctors.

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5 Multirational Management in Tourism

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The management of a tourism management and marketing organisation is multirational since there are always different stakeholders at work. This chapter places an interview with the manager of St. Gallen-Bodensee Tourism at the centre of its considerations. In addition, the authors present a brief interpretation against the background of the current debate in the field of tourism sciences.

5.1 Context

The present case discusses the management challenges in the environment of multiple rationalities on the basis of the example of a medium-sized tourist marketing organisation, St. Gallen-Bodensee Tourism. Such an organisation, which is often also called a destination management organisation or destination marketing organisation (DMO), covers a wide range of different tasks and is therefore multilaterally legitimised but equally multilaterally called upon by various stakeholders to act in their interest. For one thing, it fulfils marketing functions (usually viv-à-vis end customers, i.e. guests) on behalf of tourism organisations and organisations related to tourists/guests, knowing that a tourism product usually requires a network of providers. For another, it is often also involved in touristically relevant planning functions in one place while additionally fulfilling a certain lobbying function for the benefit of tourism development.

Such organisations are still mainly funded by visitors' and accommodation taxes, which are hypothecated for services on site and must therefore be used for the benefit of guests. A further central source of funds is the public purse (municipality, canton). Membership fees and contributions to marketing platforms are additionally paid by tourism service