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Saying what you do and doing what you say: The performative dynamics of lean management theory

Working Paper n. 35/2013
December 2013

ISSN: 2239-2734
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Saying what you do and doing what you say: The performative dynamics of lean management theory *

(July 2013)

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Abstract

Why are certain theories able to impose themselves and influence organizational practices in a significant way? Rooted at the intersection of inquiries into management fashions and into performativity, we investigate the case of the Québec public health care system, where a managerial theory – that of “lean management” – has recently emerged, gained saliency and become dominant in organizational practice. Adopting a longitudinal and multi-level research approach, we focus more precisely on the conditions that allow performativity to occur and increase, considering how this process unfolds over time. We therefore study the processes and the conditions through which lean management theory imposed itself, both in the global health care system and in two distinct health care organizations and the processes and the conditions through which this theory, while imposing itself, constructs a reality for these organizations, eventually reinforcing the theory itself. By unveiling the action of three performative dynamics in this particular case, our study provides a reflection on the catalysts and inhibitors of performativity, that goes beyond the specific case and that could be relevant to researchers interested by performativity.

Keywords: performativity, lean management, health care, organizational dynamics

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This research was made possible by funding from the Canadian Institutes of Health Research and from the Social Sciences and Humanities Research Council of Canada.

* Paper presented at the 29th EGOS Colloquium, Montréal, Canada, July 4-6, 2013; Sub-theme 52: Organizing performativity: The practical life of theory across time and organizational settings.
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INTRODUCTION

Why are certain theories able to impose themselves and inform organizational practices? This question has intrigued management scholars for many years. In this paper we will address this issue adopting a performativity lens (Callon, 1998; 2006; MacKenzie & Millo, 2003; MacKenzie, 2005; Butler, 2010). Grounded in the assumption that language is not limited to saying things, but can actually accomplish things (Austin, 1962), performativity studies maintain that theories modify actors’ decisions and actions and hence perform the reality they purport to explain. Compared to, for example, management fashion studies (Abrahamson, 1996; Benders & Van Veen, 2001; Zbaracki, 1998; Giroux, 2006) that investigated processes of diffusion, adoption, or translation of ideas, performativity studies share a focus on both discourse and practice, simultaneously. If management fashion studies address, among others, the characteristics of a popular discourse, performativity studies focus on how those characteristics interact with other elements, are put into action and generate actions and meanings. Indeed, when studying performativity, both discourses and reciprocal adjustment of heterogeneous elements, namely the combined agency of actors, concepts, and tools (Callon, 2007; Cabantous & Gond, 2011) are considered. Therefore, we believe that performativity is a highly relevant concept that can shed light on the subtleties of how a new management technique appears, is adopted by organizations, becomes popular and modifies these organizations. However, the conditions and contexts that allow performativity to occur, increase and be maintained over time are still understudied. While mechanisms that make a practice performative have begun to be identified (see Cabantous & Gond, 2011), how these mechanisms operate concretely and over time still remains to be illustrated.

We ground our analysis in the context of the Québec public health care system, where a managerial theory – that of “lean management” – has recently emerged, gained saliency and become dominant in organizational practice. As Denis (2006:9) has summarized, “performativity always goes with a specific world it participates in establishing or in maintaining.” This idea can be transferred to our context: what is this world that lean management contributes to creating, in Québec’s health care system, and how? Following the theoretical background and methods sections, we provide answers to this general question (a) by illustrating the rise of lean management in the Québec health care system; (b) by showing how lean management is a theory that imposed itself over time in the sector and how this theory, while imposing itself, is performing a reality for Québec health care organizations; (c) by unveiling the specific dynamics that allow this movement between theory and practice. These
findings will then constitute the ground to discuss potential catalysts and inhibitors of performativity more in general.

**THEORETICAL BACKGROUND**

**Management fashions and performativity.** As defined by Abrahamson, in the field of management, a fashion is defined as a "relatively transient collective belief" (1996:257). More precisely, fashions can be defined as "the production and consumption of temporarily intensive management discourse, and the management changes induced by and associated with this discourse" (Benders & Van Veen, 2001). Many managerial tools and techniques have been considered as fashions, including total quality management (Zbaracki, 1998; Giroux, 2006), business process reengineering (Benders & Van Veen, 2001:33) and ISO norms (Boiral, 2003). Lean management has also been considered in this light (Benders & Bijesterveld, 2000). These studies aim at understanding why and how these techniques become popular and disseminate in organizations. Two main lines of inquiry can be found in this literature. On the one hand, a number of studies consider the arguments that are mobilized in the diffusion of management fashions, and consider these fads as "products to be sold"; these studies focus on the actors (fashion setters, like consultants and academics, and adopters) and the dynamics that are created. On the other hand, fashions have also been investigated through the lens of sociology of translation, where the popularization of certain ideas results from an *intéressement* process (Callon, 1986); these studies show that fashions are the fruit of the cumulative efforts of a variety of actors, and that they are discursively adapted, constituted and reconstituted to fit with the values and interests of the communities to whom the ideas are aimed (Giroux, 2006). Both these lines of analysis consider the characteristics of ideas that become popular. They show that in order to become a fashion, a managerial idea or technique has to be attractive, but also ambiguous enough for it to be interpreted by a variety of practitioners all working in different contexts (Benders & Bijsterveld, 2000). This possibility of reading multiple ideas into the same concept has been labeled *interpretative viability* (Benders & Van Veen, 2000) while the openness to multiple courses of action has been called *pragmatic ambiguity* (Giroux, 2006). For example, Giroux (2006) describes how the growing popularity of a managerial idea (in her case, quality management) was accompanied by a gradual extension and blurring of the concept; others (Nicolai & Dautwiz, 2010) have shown how this ambiguity varies and how organizational actors contribute to this process.
The notion of “performativity” has rarely been applied explicitly to studies of management fashions. However, we believe that this concept is highly relevant to understanding the subtleties of how a new management technique appears, is adopted by organizations, becomes popular and modifies these organizations. In its simplest form, the notion of performativity draws on Austin’s (1962) work, in which he showed how language is not limited to saying things, but can actually accomplish things. In his original formulation in the context of “speech acts”, language is said to be performative when the act of speaking produces the effect spoken of. In other words, language does things and makes people do things. From its linguistic roots, performativity is a concept that has since travelled greatly. Denis (2006) identifies four streams of research on performativity, which include one stream in gender studies (following Butler’s work, 1988), and another in organizational communication, as in the “communicative constitution of organization” (CCO) perspective (e.g. Taylor & Van Every, 2000; Cooren, 2004). Scholars of actor-network theory (e.g. Strum & Latour, 1999; Latour, 2005; Law, 2009) and more recently, those interested in market sociology (e.g. Callon, 2007; Callon, Millo & Muniesa, 2007; MacKenzie, 2005) have also been at the forefront of reflections on performativity, and this stream is especially relevant for our study. These investigations have looked at how economic theories and models modify the decisions and actions of economic actors and come to play a structuring role that makes the theories and models closer to the reality they purport to explain.

As formulated by MacKenzie, the concept of performativity, as applied to economic science, refers to the idea that “an aspect of economics is used in economic practice, its use has effects, and amongst those effects is to alter economic processes so as to make them more like their depiction by economics.” (2005:23). Starting from the idea that there is “no economy without economics,” Callon (1998) proposed to move from economics to consider economization in order to expose the performative relationship between economics and markets (Callon, 2007). From this reformulation, economization is conceived of as a process and as an accomplishment. As Callon suggests, such a move implies that the relationship between theoretical descriptions and observable phenomena is not constative (i.e. theories describe and represent phenomena) but is rather performative (i.e. theories participate in the phenomena in question, enacting them). This stream of research also moves away from austrian performativity (where the fit between a theory and a market would be almost perfect) to what Kjellberg and Helgesson (2006) have called generic performativity, where theories and ideas shape social realities, but in a partial way. This generic performativity takes into consideration the multiplicity of practices and realities, opening the door to tensions, controversies and conflicts. In turn, this multiplicity
brings to light the constant and yet undirected work accomplished by all actors when playing simultaneously with the ideas, the tools and the practices.

As Law and Urry (2004: 396) underline, this does not make the world any less real: to the reality of phenomena, performativity adds a layer of relationality, as what is real is also made in and through social and material relationships: “we are saying that the world we know in social sciences is both real and it is produced.” Also, performativity can be seen as being a form of actualization (Denis, 2006): because of this property, something becomes actualized. For example, referring to the relationship between a theoretical formula and the reality to which it is applied, Callon writes: “[w]e could say that the formula has become true, but it is preferable to say that the world it supposes has become actual” (Callon, 2006:15); moreover, this actualization is the result of complex sociotechnical agencements (or connections) between a variety of ideas, actors, and the tools they use. It is when taken together that all of these elements contribute to performing “something”, like a market (Sjögren and Helgesson, 2007), rational decision making (Cabantous and Gond, 2011), strategy (Kornberger and Clegg, 2011), marketing (Araujo, 2007) or accounting language (Fauré, Brummans, Giroux and Taylor, 2010), amongst others.

In simple terms, the concept of performativity re-specifies the relationships between theories and realities, suggesting that statements about the world and the world itself are in continual co-evolution (Callon, 2007). Following this idea, the interesting question to elucidate becomes how does this process happen? Making these things – like markets and strategies – happen (cf Callon, 2007) requires collective work where materiality has a central role to play, as to become “actual”, these elements have to be processually inscribed in the world through objects, texts, and other complex apparatus. But where should one start? Considering the case of rational decision-making, Cabantous and Gond (2011) have developed a model that can be useful to investigate social phenomena from the perspective of performativity. They start by noting that any performative practice rests on a co-presence of theory, actors and tools. This leads them to identify three mechanisms that each serves to establish and maintain the relationships between these elements: conventionalizing, the mechanism through which a theory informs actors who value the ideas in question, engineering, the mechanism through which tools are developed according to the theory, and commodification, the mechanism through which tools move towards actors, via the creation of markets or spheres of influence. It is when taken together, and through the processes implied and activated by each mechanism, that elements can be viewed as performing something. Figure 1 illustrates this model.
In sum, performativity is a concept that opens up to critical investigation the relationships between theories and ideas on one side, and reality and practices on the other. As applied to the context of our study, the concept of performativity leads us to explore how the current lean management discourse influences and orients actors of the Québec health care sector. How does this discourse influence them to make certain choices and to undertake organizational change initiatives?

**Lean management.** The root of lean production and management can be found in the approach developed by Taiichi Ohno at Toyota (see Womack et al, 1990). The Japanese practitioners who developed this approach did not refer to it as “lean”: they rather called this approach the Toyota production system (Ohno, 1988) or the Toyota management system (Monden, 1993). The label “lean” came after it was re-articulated by academics (Morris & Lancaster, 2006). The links between the Toyota production system and lean management are therefore strong, the latter being inspired by the former. Lean management rests on an idea that is simple to summarize: “to do more with less”. It aims to improve the efficiency of organizations by eliminating all forms of waste and by considering work processes with attention. Among its key ideas, there is efficiency, cost reduction through waste elimination, just in time and respect for workers. As an approach, lean management promises to create production systems organized around optimal decisions for every stakeholder (employees, clients, etc.).

Since its popularization in the 80s, lean management has been widely used in manufacturing companies, and is currently one of the most influential production paradigms (Holweg, 2007). In the 90s, this approach started to be applied in other contexts than in industrial production, and in particular in health care. In this sector, lean management approaches are presented as improvement programs whose expected results are clear: improvement in service quality, better
care, improved efficiency of activities (Van den Heuvel, Does & de Koning, 2006). In a context where public funding is shrinking and where the level of bureaucratization seems problematic (multiplication of protocols and paperwork), lean management appears as a promising approach for health care (Cooper & Mohabeersingh, 2008). This may explain why this approach is becoming more and more popular (Papadopoulos & Merali, 2009; Cooper & Mohabeersingh, 2008; Durward & Lang, 2010), and also why there seems to be an explosion of books published on the topic, either describing the ‘toolbox’ of lean and offering prescriptions to ensure successful applications (e.g. Graban, 2009; Wellman, Hagan & Jeffries, 2011; Zidel, 2006) and/or presenting success stories (e.g. Black and Miller, 2008; Kenney, 2011). Lean management can involve the use of a plethora of concepts and tools. Table 1 presents an overview of some of these concepts and tools, as we can find them mentioned in health care.

### Table 1. Lean management concepts and tools, as applied to health care

<table>
<thead>
<tr>
<th>Core lean management concepts</th>
<th>Most common lean tools and techniques</th>
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</thead>
<tbody>
<tr>
<td>&quot;Harder aspects&quot;:</td>
<td>- Value stream analysis (flow analysis)</td>
</tr>
<tr>
<td>- Waste and costs reduction</td>
<td>- 5S (a technique to insure cleanliness and orderliness)</td>
</tr>
<tr>
<td>(through a careful planning of tasks and work processes);</td>
<td>- Process analysis and mapping</td>
</tr>
<tr>
<td>&quot;Softer aspects&quot;:</td>
<td>- Kaizen (participation of individuals in continuous improvement of processes)</td>
</tr>
<tr>
<td>- Respect and empowerment of employees;</td>
<td>- Poka-Yoke (&quot;mistake proofing&quot;: a technique to draw attention, correct and prevent human errors)</td>
</tr>
<tr>
<td>- Focus on patients’ needs and quality of care</td>
<td>- Kanban (a scheduling system for &quot;just-in-time&quot; service delivery)</td>
</tr>
<tr>
<td></td>
<td>- Standardization</td>
</tr>
</tbody>
</table>

In other words, lean management is currently attracting considerable attention in health care, and it has even recently been associated with innovation in the public sector (Papadopoulos, 2011; Pedersen & Huniche, 2011). Lean management does share some similarities with other management approaches that have been deemed “fashions”, like business process reengineering and total quality management. It is therefore an interesting object of research for those concerned with performativity.

**METHODS AND EMPIRICAL SETTING**

This study builds on ongoing research in two public health care organizations located in the province of Québec. We opted for a focused ethnography approach (cf. Knoblauch, 2005), which relies on short-term visits and a field-observer role, and is particularly attentive to
communicative activities. This fieldwork was completed with a study of various documents related to the health care sector in Québec. Our study therefore combines organizational and sector level investigations.

**Organizational level: two case studies.** This study started in 2011 with the aim of investigating strategy and leadership in two health care organizations from a practice perspective. Both of these organizations are Health and Social Services Centres (HSSC), i.e. local health care organizations depending on the Québec Ministry of Health and Social Services. Based on these ongoing observations, we were able to identify that concerns surrounding lean management in health care were becoming progressively more present in discussions and decision-making. We therefore decided to investigate in more detail the rise of this concern, and how it impacted each organization. The two health care organizations in question, Omega and Kappa, are located in metropolitan areas. Although they both belong to the same public and provincial health care system, these two organizations differ from each other on many dimensions (e.g. territory, population characteristics, main activity sectors, size, etc.). Table 2 presents some of the key characteristics of Omega and Kappa.

### Table 2. Comparison of the two HSSCs studied

<table>
<thead>
<tr>
<th></th>
<th>HSSC Omega</th>
<th>HSSC Kappa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Region</strong></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td><strong>Size of top management team</strong></td>
<td>22 persons</td>
<td>15 persons</td>
</tr>
<tr>
<td><strong>Main activity centers</strong></td>
<td>Acute care hospital/ Nursing homes/Home care/ Social services</td>
<td>Nursing homes/ Home care/ Social services</td>
</tr>
</tbody>
</table>

During 2011-2012, we observed forty-three top management meetings for both organizations. We could not record the meetings, but were able to take notes. Although we do not have the exact conversations that took place during each meeting, we still have detailed notes about all the topics that were discussed, who took part to these discussions, the key elements of what happened during these discussions and their results, in particular, the decisions that were taken. We also conducted interviews with members of each top management team. Lasting between one to two hours, thirty-one interviews in total were conducted: fifteen people were interviewed at Omega, and sixteen at Kappa. All interviews were taped and transcribed. Finally, we also collected all the documents associated with all top management meetings that happened during the time period when we were doing this fieldwork. Analysis of the observation notes and
interviews was done with the N'Vivo software. The research question that guided our analysis of this material was: how did each organization take up the lean management discourse? More precisely, how did this discourse penetrate their decision-making, strategy and leadership processes, and through which mechanisms did this discourse progressively gain traction and infiltrate activity?

From the transcriptions of meetings and interviews, and from organizational documents we collected, we started by looking for all passages that referred in any form to optimization or lean management in each organization. When this first wave of coding was completed, we engaged in a second cycle of semi-structured coding, this time mobilizing the categories (theory, actors, tools) and mechanisms (conventionalizing, commodifying and engineering) described by Cabantous & Gond (2011), in order to gain a finer understanding of how the lean management discourse gained traction in each context. We refined this coding by building themes and sub-themes as they emerged progressively from the analysis of our material. In this process, we also paid particular attention to the gradual unfolding over time of this phenomenon. This attention allowed us to trace and compare the various practices and dynamics that surrounded the discourse of lean management in the two organizations.

**Sector level: documentary research and interviews.** In parallel to the fieldwork and to the analysis of its material, we collected a variety of materials linked to lean management in the Québec health care sector. This material is composed, among others, of Ministry of Health and Social Services documents, newspaper articles, consultants’ presentations and reports on this topic, press releases of other health care organizations and documents produced by different actors. The question that guided this work was how prevalent is the discourse of lean management in the Québec health care sector? We used this data collection and analysis to chronologically trace the appearance, emergence and focusing of the discourse.

Following a first phase of exploration, we decided to deepen our analysis of the content of some of these documents, namely the Ministry documents and newspaper articles. After a thorough reading of these passages, we singled out the actors who were mobilizing a lean management discourse, their main arguments, the specific labels employed (e.g. “lean approach”, “Toyota method”, etc.). Moreover, we looked for concrete examples of application of lean, identified the effects or consequences (positive and negative, observed and expected) of lean management and characterized how the actors talked about it (positively, negatively, neutrally, with caution or with irony). This work allowed us to first establish that over the last five years, a discourse on
lean health care management emerged in Québec, and secondly, to show that this discourse became more and more important over time. Finally, we have also conducted five interviews with various actors involved in the healthcare sector (physicians, consultants, political actor), in order to learn more about the evolution of Lean management in Québec.

We present our findings in the next three sections and we organize them as follows. First, we provide a descriptive analysis of the emergence and evolution of lean management in the Québec health care system. Next, we provide evidence of performativity, both showing how lean management has become the way actors think and speak of health care in Québec (a new theory), and how this theory is not neutral, but is performing a new reality, in the form of new subjects, new objects and new debates that are created (a new practice). Finally, we unveil three specific dynamics acting as the conditions that make performativity possible.

THE CASE: EMERGENCE AND EVOLUTION OF LEAN MANAGEMENT IN THE QUÉBEC HEALTH CARE SYSTEM

In this section, we present how lean management appeared, emerged and evolved over time in the Québec health care system both at the sector level and at the organizational level, within the two HSSCs studied.

Sector level: The rise of Lean in the Québec health care system.

The Lean management discourse entered the Québec health care system around 2004-2005, and it rapidly gained momentum and grew in potency. This trend is visually outlined in Figure 2 and described in detail in Table 3. As in the case of other health care systems around the world, the goal to “optimize” health care services, in terms of more efficient use of resources and reorganization of processes, was already in the air. Following its appearance on the Québec scene, an increasing number of people started to be interested by lean management. At first, a few isolated political players, medical associations and some consultants started to mention sporadically lean management in relation to health care (see dotted lines in Figure 2). A first turning point marked the transition from this introductory phase to a second one: the appointment of a new health Minister who officially espoused lean management as the cornerstone of his mandate (2008; see the first arrow in figure 2). Lean management got a new
impulse, as from that moment on it started to be presented by the health Minister as *the* way to reach the optimization goal. This marked the beginning of a popularization phase: lean management became progressively the object of consultants’ intervention, of seminars and of debates in the general press; moreover, resource and process optimization were introduced as formal objectives of all strategic plans at ministerial, regional and organizational levels, along with the portrayal of lean management as the best means to achieve this. The multiplication of actors talking about lean management in the Québec health care system is represented by a multiplication of lines in this phase in Figure 2; and the intensification of the discourse, in terms of number of references to lean management for every actor in public documents is represented by the passage from dotted lines to full lines in this figure.

A second turning point marked the transition from this popularization phase to a different phase: a call for “optimization projects” to be financed, launched by the Ministry in collaboration with a consulting firm specialized in ‘lean health care’ (2011; see second arrow in the figure). This, coupled with the mentioned appearance of optimization goals in every health care organization’s strategic plans, contributed to transform lean management from a generic recommendation into a quasi-obligation for all public health care organizations.

**Figure 2. Timeline of the lean management discourse emergence**
Table 3. Phases of the Lean management discourse’s emergence at the sector level, 2005-2012

<table>
<thead>
<tr>
<th>Phases and turning points</th>
<th>Key elements</th>
<th>Key result</th>
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</table>
| INTRODUCTION PHASE        | • The lean discourse timidly starts to appear in the Québec health system in the mid-2000s. But the first concept that appears is that of “optimization” (of resources and processes).  
                          | • Lean management makes an appearance in 2005 and 2007 among the objectives of the health Ministry in its strategic plans and annual reports; in 2007, the then Minister makes an influential speech on the need to reform the system by introducing optimization measures, opening the first public discussions on this in the press. The need to optimize health care services is also stressed in 2007 in the Auditor General of Québec’s annual report. It is hence included as a general recommendation for all health care organizations.  
                          | • Medical associations too start referring to the concept of optimization and to the need of increase in productivity, reporting some first examples of application of the lean management principles in operating rooms in Québec.  
                          | • Along with this, some consultants and academics specialized in lean health care start to intervene in public discussions in the press, in conferences, and on their websites to underline the importance and the need to apply optimization principles to public health care services too. | A discourse of “optimization” starts floating is in the air                                                                           |
| Turning point 1:          | • After the concept of “optimization” already been adopted as the new general goal for health care, “Lean” is then introduced as the way to achieve such goal. This follows the appointment in 2008 of a new health Minister. This individual, a physician and a former general director of a HSSC, was already known in the sector for the application of lean management principles in the operating and emergency rooms of the hospital formerly under his direction. He strongly leveraged his successful experience to promote his appointment as the new Minister of Health. His promotion of lean management is so clear that his name becomes tightly coupled to it (a press article in 2008 even mentions “the [minister’s name] method” to refer to lean management approaches in health care).  
                          | • Most of his public talk reported by the press deals with the description of the notion of lean management in health care, the mobilization of the same few examples of allegedly successful applications of lean management in optimization projects (all in the context of the re-organization of work processes in operating and emergency rooms), and the beneficial consequences of optimization: for the patient (reduction of waiting times, increase in surgeries performed, performance improvement), for employees (motivation, empowerment, greater participation in organizational rethinking), and for the organization (cost savings). | The table has been made: lean can be framed as the solution                                                                           |
| POPULARIZATION PHASE      | • In 2008, a boom in the number of press articles addressing the topic of lean health care takes place (from 23 to 44 between 2007 and 2008), dominated by the interventions of the new Minister, who makes the discourse on lean management circulate by repeating it and insisting on it at every public occasion. The general press relays his message.  
                          | • These constant references to lean management by the Minister ignites a debate. The number of press articles addressing the topic explodes in 2009-2010 (from 44 in 2009 to over 100 in 2010). The one-way, Ministry-driven, enthusiastic tone of the first phase becomes fragmented by various voices (unions, medical associations, | Lean management is the talk of the town                                               |
• This deepens the topic of lean health care, as flyers, presentations, articles in specialized magazines, and ad hoc conferences are organized by medical associations, unions, health care organizations. Critical views are also expressed, focusing on the possible negative consequences of lean health care, such as personnel burnout, excessive standardization of processes, no obvious reduction of resources, etc.

• Meanwhile, the press starts reporting more and more cases lean management applications or of “optimization projects” in operating and emergency rooms of several Health and Social Service Centres in Québec. The presence and intervention of consulting firms in these projects is also underlined.

**Turning point 2: The call for optimization projects 2011**

- Once the lean management discourse has become popularized and can be seen as having penetrated the public discourse – oscillating between enthusiasm and criticism – it rapidly shifts status from being a strong recommendation to becoming a quasi-obligation for all public health care organizations in Québec.

- Two main events mark this change. First, the inscription of formal optimization objectives, targets and indicators in all strategic plans (2010-2015) at the Ministry level and, consequently, in all of the regional agencies and of all individual HSSCs. This makes optimization and lean management (as the way to reach it) a strategic priority, for which all HSSCs would be held accountable.

- Second, a ministerial call for “optimization projects” (called Lean Healthcare Six Sigma) is issued. This call sanctions Lean as the way to obtain optimization (Spring 2011). The call was linked to a budget of 12 million CAN$ to be destined to the three best optimization project proposals. This budget would sponsor the work of external consultants that would be expected to train the selected HSSCs and to support them in the setting up and carrying out of the projects. The call for optimization projects works as a lever to reinforce the ministerial quasi-coercive imposition of the optimization targets. In fact, through the call for projects, the strong recommendation for HSSCs to adopt and deploy lean management principles to achieve optimization was now anchored to concrete elements (an ad hoc budget, the related provision of a consulting service and the visibility entailed by the “pilot project status”).

**TRANSFORMATION PHASE 2011-2012**

- Lean projects are being deployed in HSSCs

| Lean management becomes a quasi-obligation |

| Lean management is in movement in HSSCs |
Organizational level: Lean management discourse in two health care organizations.

Shifting now the focus from the sector to the organizational level, we can see how a lean management discourse was espoused at a different pace and through different trajectories by our two focal HSSCs, Kappa and Omega. It should be noted that at the organizational level the terms "lean" and “optimization” are often used interchangeably. Although optimization might be seen as the goal to be achieved and lean the approach through which to reach that goal, in fact organizational actors commonly talk interchangeably about “lean projects” or “optimization projects” to address the same phenomenon, i.e. the need to improve productivity. These two trajectories are presented not because we have found them to be exemplary; rather, their respective trajectories allow us to explore how, at the organizational level, lean management appeared, reoriented and reshaped decisions and some of the strategic choices.

Broadly speaking, at Kappa, lean management entered the organization as an operational concern, immediately associated with localized initiatives. Only secondly was it integrated as a seriously-taken strategic concern. This process can be summed up as a trajectory of “prioritizing”, where different elements competed and concurred in integrating the discourse of optimization into the organization, hence moving it from an operational issue to a more strategic status. In the other organization, Omega, we witnessed the opposite movement. Lean management started as a strategic concern, as it was already spoken of and identified as the cornerstone of the strategic plan for 2010-2015. Only then did it move toward operationalization, in terms of actual training and of concrete projects to be realized. Omega thus followed what we labelled a trajectory of “concretization”, from a strategic intention to a recent operational concern. Table 4 develops these two storylines.

All in all, Kappa and Omega started from different positions towards lean management and portray two distinct trajectories (one of prioritization and one of concretization) of the surge of a lean management discourse at the organizational level. Despite their differences, both trajectories led to the same point of convergence: lean management became an espoused strategic priority instantiated into several localized projects.
Table 4. Two stories, two trajectories of lean management integration

<table>
<thead>
<tr>
<th>Kappa</th>
<th>Omega</th>
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<tbody>
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<td><strong>Prioritizing lean management</strong></td>
<td><strong>Concretizing lean management</strong></td>
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<td>The notion of optimization was introduced at Kappa by the General Director in 2011 and was justified to the rest of the top management members as a ministerial obligation impacting all HSSCs in Québec. At first, Lean was an object of humour and irony, as the members of the top management team “played” with the optimization discourse, displaying an ironic distanciation during meetings (e.g. a director says that all HSSCs that the Minister brings as examples of optimization are present everywhere [in every congress] “and they brag about their initiatives”). But soon, it became an operational concern: the notion of optimization was mobilized during the preparation of the operational plan 2011-2012; the top managers discussed the opportunity to connect their individual projects with the organization's operational objectives on optimization; it started being acquired as a common language (e.g. “this is not lean!” while referring to a project) and as an acquired work practice, associated with localized initiatives already underway. Lean also progressively started to serve as a basis to structure new organizational initiatives. Finally, lean management ended up being understood and integrated as a serious strategic concern, becoming an organizational imperative and a new management philosophy used to instill cultural change – and not just something that must be done to simply comply with demands coming from the Ministry.</td>
<td>The first sub-period (Winter 2010/2011) was characterized by a diffuse yet generic talk of lean management during top management meetings (e.g. “the intention of becoming lean”; “a lean-oriented project”). In the following quote, the General Director makes an even more explicit point on how some of the principles of the lean management approach have inspired the strategic orientation of Omega: [W]e adopted our Strategic Plan 2010-2015 as a management frame, as a reference model to apply a management system based on listening, on respect, on trust, on values that actually were already there, but that we have now applied them in the everyday, we trained…. I trained my managers, my managers trained their middle managers, and yes, we were inspired by Toyota, but in the sense that we adapted it […]. And now we are in the process of applying this model...[General Director, Omega, March 2011] At this stage, there is no mention of specific optimization projects, applications, techniques employed or other concrete initiatives beyond the more general strategic intention to integrate an “optimization culture” within the organizational vision. “We are not operational yet, I didn't start the problem solving, the engagement of employees, the visual mapping of... I'm not there yet, but in terms of approach, of learning, of culture, [the lean management approach] is acquired [...]. Put differently, I wasn't looking for short terms gains, I tried to move toward a new organizational culture.” (General Director, Omega, March 2011). However, after working on inscribing lean management in the organizational culture, the need to “go operational”, i.e. to concretize this culture change, started to emerge in Omega. “We are going to develop the operationalization of all this learning, and we are going to make it live in everyday work. We are applying it now” (General Director, Omega, March 2011). This is substantiated in the hiring of consultants specialized in lean management, in the creation of an ad hoc committee to overview the deployment of lean projects, and in the declared intention to identify specific projects.</td>
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EVIDENCE OF PERFORMATIVITY: A NEW THEORY AND A NEW PRACTICE

This surge of lean management discourse – in the health care sector in general, and in the health care organizations in particular – is an indication that a new way to portray health care has emerged and gradually imposed itself in Québec, from health care to “Lean health care”. A new way to portray the health care sector is a new way of seeing it, of thinking about it – in other words, a new framework for health care.

Lean health care as a theory. As we saw, the basic idea of lean management is “to do more with less”. Organizations can improve their efficiency by eliminating all forms of waste and by considering work processes with attention. We can see lean management as a holistic organizational theory, i.e. a specific way to see organizations, resting on a set of interrelated concepts (waste and costs reduction through a careful planning of tasks and work processes; respect and empowerment of employees; focus on patients’ needs and quality of care); actors (empowered employees), and tools (like 5S, process analysis and kaizen). This rests on several assumptions: first, that reality is objective and measurable; second, that individuals hold a strong rationality; third, that, as a consequence, optimal solutions can be found and implemented locally. The more individuals act according to rationality on the basis of objective assessment of their surrounding reality (work processes and problems), and the more they are empowered to provide local solutions, the more efficiency (in terms of use of resources and organization of processes) and effectiveness (in terms of quality of the service) are maximized. As a consequence, then, the whole system is optimized and the wellbeing of both workers and patients enhanced.

In turn, this framework generates a new way of conceiving the health care system in Québec. First of all, the surge of a lean management discourse in the Québec health care system is not a neutral accomplishment. In fact, the more lean management is spoken of, the more it frames the way health care services are portrayed, as it imports the very assumptions it is based upon. We will now show how these assumptions are embedded in the local discourses. First of all, health care services are indeed increasingly framed as something objective and measurable:

“Some regions are experimenting ways to analyse clinical performance, all along with emerging promising models in the system (the LEAN approach)”. [Strategic Plan (2010-2015) of a health care regional agency]
It is further assumed that an objective appraisal of the services is what makes them both open to
be planned and to be implemented in the best way:

“LEAN, Six Sigma, Kaizen, etc. [...] all rest on a similar cyclic approach that consists of four steps: to
plan, to realize, to appraise, to act” [Strategic Plan (2010-2015) of another health care regional
agency]

“The general idea is to increase the value of the product while decreasing what does not contribute, or
contributes marginally, to its creation, that is qualified as unnecessary” [Ministry Bulletin, April 2009]

Several criticisms emerged in the public debate on lean management, depicting lean
management in health care as an industrialization of complex professional services, speaking
frequently of "assembly lines", or of treating "hospitals as factories" (in reference to the
manufacturing origins of Lean management). While contesting it, these views are indeed
confirming that underneath the lean management discourse, there is a new way of thinking
about the health care sector, one based on rationalization. Moreover, the assumption of
individuals acting linearly and according to strong rationality is evident here too. In particular,
the lean management lens portrays professionals not as mere executors, but as empowered
actors having the ability to analyse and provide the most optimal organizational solutions:

"Lean is a method of process reengineering where human resources are at the centre of the process
and where clients needs are what determines the production. As opposed to other process
reengineering methods, the strength of process change comes from the bottom of the organization,
rather than from its top management" [Ministry Bulletin, April 2009]

"Globally, the Lean Healthcare approach rests on a rigorous and structured approach of problem
solving and it requires the engagement and the participation of all organizational members – and this,
at all hierarchical levels (board of directors, general direction, middle managers, professional and
medical managers, personnel and physicians). However, it is the so called "field" members who live
the problems in their everyday, that should demonstrate creativity in revising the procedures and the
functioning of the services, in order to identify the truly adequate solutions for their situations".
[Communication of one of the HSSS selected in the call for projects (2011)]

Finally, local discourses also refer to the postulated outcomes of the general process of
optimization:

“In a perspective of necessary optimization for the re-establishment of a budget balance, as well as for
potential benefits in terms of effectiveness and efficiency, the managers of health care organizations,
in accordance with the Agency, have agreed to start up three regional projects of optimization”
[Strategic Plan of a health care Agency (2010-2015)]

“In the spirit of collaboration and engagement, we invite all actors and partners of the field to take up
successfully the challenges for the next years to come, targeting optimization in the use of resources
and on the continuous improvement of the performance of our network, in order to respond to the
health care and social services needs of the Québec population” [Strategic Plan of the health care
Ministry (2010-2015)]
In sum, the health care system is portrayed as something objective and measurable; following a diagnosis, its services can and should be planned in the most efficient way, and what is scheduled can and should be implemented accordingly by rational individuals at any organizational level, eventually leading to the ‘happy ending’ of optimization and maximization of all stakeholders’ satisfaction. Even if different local interpretations of lean management may exist, various actors all seem to have interiorized the idea that lean management is a – if not the – new way to look at health care services in Québec. In this sense, we can conclude that a new spoken theory has really imposed itself, even if contestation has been voiced by various actors, such as unions or group of workers.

Practices enacting the new theory. The analysis of this case reveals that the emergence of this new way of conceiving how health care should be organized and managed is accompanied by a series of practices triggered by the growing presence of the lean management discourse. The new theory proposed by lean management does not simply offer principles or a new way of managing health care organizations; it does not simply “diffuse” in this specific context. Its entry on the health care scene in Québec in fact transforms this scene: lean management partly creating and reshaping the reality in which these organizations evolve. If the lean management discourse is spoken by a variety of actors – mentioned as a rationale to enact organizational changes, used as a consultant’s sales pitch, presented as a quasi-evidence for the sector and even contested by its opponents – it also inscribes itself in reality by giving rise to a variety of events and manifestations. All of these events contribute to propagating lean management – its philosophy, its tools, its expected results – to a growing number of actors, and also in setting in motion the transformation of health care that lean management promises to bring about. Based on the data we have collected, it is possible to identify practices that have co-evolved with the introduction and prevalence of the lean management discourse. We have labelled “practice” a recurrent form of action in the health care sector. Each practice is illustrated by examples of events.

Table 5 presents evidence we gathered in the health care sector, over the 2008-2012 period. Based on our documental analysis, in this table show the main events related to lean management (main practices and related examples, displayed in the first and second column, respectively) and the main concrete effects they led to, further grouped in broader categories (third and fourth columns, respectively). These categories of effects show that the lean management discourse’s penetration can be understood as being more than a “new technique” – or a management fashion – that would be adopted and appropriated by actors in the studied...
sector. Rather, the lean management discourse does things, performing the lean management reality over time on three distinct planes: constructing new subjects, new objects and new ideas and controversies.
Table 5. Practices that set and keep lean management in movement

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<tr>
<th>Practice</th>
<th>Examples</th>
<th>First level effects</th>
<th>Second level effect</th>
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<tr>
<td>Training for lean management</td>
<td>Information on lean management is developed and circulates in general press and through brochures produced by associations (e.g. the nursing association of Québec)</td>
<td>- Lean management is defined and distinguished from other approaches.</td>
<td>Construction of new subjects For example: - Lean management itself personalized (“the lean”; “lean does this”; “lean allows that”); - Lean management champions; - Lean HSSS - The community of practice itself</td>
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<td>Colloquiums are held on lean management and on lean healthcare</td>
<td>- Lean management is diffused and individuals (physicians, professionals and managers) are trained in lean, learning its logic, its vocabulary, etc.</td>
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<td>- Case studies on application of lean principles are disseminated;</td>
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<td>- The Health Minister’s and consultants’ vision of lean as a solution is legitimized.</td>
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<td>Training sessions are organized by consultants in HSSCs</td>
<td>- HSSCs employees and managers are trained and receive titles (e.g. green belt); these titles spread; - A certain understanding of how lean management should be practiced is promoted.</td>
<td>Construction of new objects For example: - Measurable objectives; - Measurable outcomes;</td>
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<td>A community of practice on lean management is created and animated</td>
<td>- Practitioners – experienced or in the process of learning – are given a space to discuss lean management; - A knowledge base on lean projects is developed, and a network of practitioners is established; - A structure to organize events and meeting on lean is created.</td>
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<td>Realizing lean management</td>
<td>“Optimization” becomes an explicit objectives in HSSCs’ strategic plans, and lean is associated to this objective</td>
<td>- Lean management is written up as a highly relevant approach to achieve this strategic objective.</td>
<td>Construction of new objects For example: - Measurable objectives; - Measurable outcomes;</td>
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<td>Resources are mobilized and devoted to lean projects; ad hoc budgets are adopted to fund these projects at the Health ministry; most of the funding is to be</td>
<td>- The Health ministry prioritizes lean management and by linking it to budgets, contributes in institutionalizing it; - The market for consulting services on lean management for health care organization is stimulated.</td>
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| Debating lean management                                                                 | Allocation to consulting firms who will help three selected HSSCs to “become” lean | - Measurable resources flows mobilized for that application of lean management are conducted first in specific services (ORs, ERs) of HSSCs, and then across whole organizations | - Lean management is tested and applied in areas where it fits well; proofs of success are used to illustrate and reinforce the discourse on lean; - Then, the possibility of “doing” lean management organization-wide becomes possible; - It becomes possible to talk of a “lean culture”.

| Results linked to application of lean management are publicized | - Lean management effects can be measured and its consequences can be “seen”. |

| Positions critical towards lean management in the context of health care are taken in the general press | - Lean management is presented in a negative light - “Dysfunctions” of lean are detailed; - Yet: this helps in propagating the knowledge on lean management. |

| Positions critical towards lean management in the context of health care are taken by unions | - The “soft” aspects of lean are presented as a way to hide the “hard” ones; - Lean management is denounced as having been constructed as a solution. |

| Manifestations against lean management are organized | - This propagates a different view of lean management, as a dehumanizing technique, akin to chain production – therefore as a change to be opposed; - It polarizes perceptions towards lean. |
These practices set in motion lean management in the sector we studied, and by doing so, contribute in making it a reality – or at least, in partially inscribing it in these organizations. This inscription happens through the multiplication of lean actors (new subjects), through the proliferation of material and measurable elements associated to lean (new objects) and by the general presence of lean ideas, especially in the form of controversies around what lean does in the health care sector. For example, by training more and more individuals in lean management and by disseminating knowledge on what lean management is, managers, professionals and employees learn about lean; some may even become keenly interested in lean management, leading them to get other certifications (such as green or black belts, titles associated to levels of training), to become lean champions in their own organizations and to get involved in lean community in their region. The presence of the lean discourse at the sector level thus creates opportunities for individuals to transform their status and possibly their place in their organization. In this process of learning about the lean management ideas, logic and vocabulary, some individuals become passionate about promoting and applying them, which in turn help in anchoring the presence of lean management in reality.

Generally speaking, by gradually making “lean management” into something that is more known, into a vocabulary that can be used to frame how the health care system might be reformed and to solve problems into something that makes actors intervene in their local contexts, the practices documented in table 5 put lean management in motion and in action. By accumulating, each of these events becomes one brick in a building that is moving from abstract idea to concrete presence. The various actors of the health care sector – each animated by diverse aims and motives, not necessarily aligned – all hear the lean management discourse differently; but despite their diversity, most of them discern something of importance in this discourse, and, through their varied actions, keep it moving from theory to practice. This snowballing effect is at the heart of the overall performative dynamics we studied. In the following section, we will examine the underlying conditions that made this movement possible. These findings will prepare the ground to discuss in more general terms what makes a theory performative, leading us to consider the genesis, the persistence and even the potential fall in the performative dynamics of certain ideas.

THE DYNAMICS OF PERFORMATIVITY
In the previous sections we showed that there is a new spoken theory that starts to be enacted by a plurality of actors and forces, becoming visible through different practices (cf table 5). This process strengthens the place occupied by lean management in the sector. At the time of our study, even the practices debating lean management can be interpreted as keeping lean present as a strong discourse in the sector. But what makes this possible? According to performativity theory, there is some reciprocal adjustment (“agencement”) of heterogeneous elements (actors, concepts and tools) going on (e.g. Callon, 1998). This agencement allows the conventionalizing of an idea in actors’ minds, its engineering into tools and its commodifying in the society (Cabantous & Gond, 2011). However, the conditions and contexts which make these performativity mechanisms move and how this process actually unfolds remains to be explained. Our case study helps us shed light on these fundamental elements that are at the basis and at the heart of performativity.

Dynamic of discursive elements: Co-presence of hard and soft elements. Let us start with the conventionalizing mechanism, defined as the cognitive embeddedness of a theory in actors’ mind and behaviour (Cabantous & Gond, 2011), i.e. the valuation of a set of ideas. Broadly speaking, we saw evidence of conventionalizing acting at the sector level in the health care system, particularly in the popularization phase (2008-2010, recall Figure 2), with the constant repetition of the basic principles of lean management by the Minister, the continual references to the exemplar cases of successful applications in some HSSCs, the insistence on the beneficial gains entailed by it, and its appearance in the ministerial formal documents and plan eventually. The Minister had already bought into lean management, and he had taken office with the clear idea to propagate it in health care. This unambiguous position taken by the Minister sent a message: lean management in health care would be valued and useful for organizations, a message that would be consistently repeated and reiterated over the years. Over time, case studies of organizations trying out lean management via optimization projects started to be known in the sector. Therefore, when lean management and optimization initiatives hardened and became expected of most organizations (transformation phase, 2011-2012, recall Figure 2), all HSSCs (or a very vast majority of them) had minimally heard about it, had heard the Minister talk about it and had seen other organizations “do” it. Through all these actions a discourse gains value and its assumptions start to be familiar and embedded in public opinion, potentially shaping actors’ mind and behaviour.

Traces of such conventionalizing process can be found at the organizational level too. For example, we saw the echoes generated in the environment within Kappa, as the lean
management discourse (especially the more technical aspects of process re-organizing and resource savings) was gradually valued, by being increasingly spoken of in top management meetings, by entering plans and becoming the new driving convention or social norm for the organization. We saw conventionalizing acting in Omega too, as the top management team captured the discourse of optimization that was in the air (especially the more cultural aspects of new organizational philosophy and of employees’ involvement) and appropriated it shaping the organizational vision accordingly.

To understand what allowed that, we looked at the contents of the lean management discourse that was mobilized. We thus unveiled the dual nature of the discursive elements constituting lean management theory. The lean management discourse combines optimisation of resources and reduction of waste with elements pertaining to human resource management: on the one side, we find “hard” elements, in the form of measurements, process reengineering and tools, and on the other one, “soft” elements, related to empowerment of workers and a form of participative management. We can see that in all cases (in the broader Quebec health care system, in Kappa and in Omega) both “harder” and “softer” elements of the lean management discourse are mobilized – technical aspects of resource waste reduction and process re-organizing, and cultural aspects of a more participatory work environment, respectively. Table 6 illustrates this co-presence of hard and soft elements through selected quotes taken out of official documents.

Table 6. Examples of co-presence of hard and soft aspects in the lean management discourse (in red, hard aspects; in blue, soft aspects)

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<td>• <strong>Reduction of time, waste elimination and process reorganization</strong> [2008, Physicians Board of Québec Bulletin]</td>
<td>• “The Agency has succeeded in sustaining an <em>optimization culture</em> in the region. Moreover, this pursuit of performance is not limited to financial performance, it is rooted in the desire for an <em>optimal use of clinical resources.</em>” [2010, Health care Agency’s strategic plan]</td>
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<td>• <strong>Targets established in %</strong> [2008, Health Minister discourse]</td>
<td>• “Lean is a <em>process reengineering method</em> where human resources at the centre of the process and where the client’s need is what determines production. Contrary to other process reengineering methods, the process change’s strength comes from the basis of an <em>organization</em> rather from upper management.” [2009, Health care Ministry Bulletin]</td>
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<td>• <strong>Importance of involving personnel in problem solving</strong> [2008, Health Minister discourse]</td>
<td>• “Even the best reforms and the most avant-garde processes cannot be implemented <em>if they are not supported by the people</em> who are integral to the [health care] network. Human factor is the centre of this change and it is there that we need to intervene. To make it, managers and the various groups of employees and professionals [...] will all need to be part of the solution. Whatever the solution/method recommended, it is human beings who offer care in the network.” [2009, a physician’s point of view presented in a physicians association bulletin]</td>
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**2011-2012 – Transformation phase**

- "Necessary involvement of employees allow to think of an improvement of quality of life at work [...] but rationalization still remains the objective."; Lean management is a "productivist approach to health care". [2011, annual congress of Québec Nurses labour organization]
- Levels of application: operational (clinical and administrative processes) and strategic (mindset, philosophy, quest for a lean culture) [2001, Health care Ministry conference]
- Lean as a management philosophy based on human resources [2011, HSSC press release]

We argue that it is the joint mobilization of these two components of the discourse (and a greater stress on either harder or softer aspects in different organizational contexts) together with the tension they create that enables an idea to be embedded in actors’ mind, i.e. to make the conventionalizing mechanism (Cabantous & Gond, 2011) move. However, a dominance of harder aspects (for example focusing only on technical ideas of a scientific measurement of all tasks in the relation with patients in emergency rooms in order to optimize the service and the related waiting times) would limit the conventionalizing of an idea (in this case the valuation of a lean management discourse by health care professionals) for its lack of humanization. Similarly, a dominance of softer aspects (if the lean management discourse was limited to its intangible component of a new work philosophy, a more participatory working *milieu* and the like) would limit the conventionalizing potential of an idea too: their intangible character might make the concepts attractive at first, but they would be short-lived, precisely because of the lack of concreteness necessary to be fully applied. In other words, principles of lean management can make it through a sector like the health care as far as their hard components are humanized by the softer component of organizational culture change, or as far as its softer and often vague components of culture change are anchored to the more concrete and applicable aspects.

Therefore, a first dynamic lies in the dual nature of the discursive elements constituting lean management theory – namely, “hard” and “soft” aspects. When these are well balanced, this dynamic of discursive elements promotes acceptability and the cognitive embeddedness of a theory.

**Dynamic of interests: co-presence of political and economic interests.** Let us now move to the second performative mechanism identified by Cabantous & Gond (2011). *Commodifying* is defined as the promotion of tools and their diffusion among actors (Cabantous & Gond, 2011). Once more, this is observable in the broader health care sector. As we have seen, the Minister took up a lean management discourse and made it its mission to impress it on the health care system. Consulting firms heard this message loud and clear. Some of them were already working
in lean management, and recognized the business opportunities this could create for them. Progressively, a market for these ideas developed. Lean management – even in its health care applications – was more and more known when this wave started to appear in Québec, and given their experiences in other sectors, consulting firms entered the field with “ready made” tools and techniques that could equip organizations interested in lean management. Indeed, some HSSCs were tempted by this approach, and became early adopters of lean management, not waiting to experiment with it, giving it a go sometimes with the help of consultants. Clearly, both in Kappa and in Omega a commodifying mechanism has been acting at different stages but in similar ways: we could observe the action of the ministerial obligation (introducing the discourse of optimization in Kappa and accelerating its adoption in Omega) and the emerging need to engage in formal training sessions of optimization or other forms of organizational learning (for example by observation of best practices of applied optimization in industrial firms, in the case of Omega). Both the action associated with legislative requirement, and the actions of consulting firms in developing a capacity to offer for sale training programs and project management for optimization have had the complementary effect of promoting and diffusing tools and ideas of optimization into the organizations.

All in all, there is evidence of both political actors (ministerial bodies) and private actors (consulting firms) that are clearly the expression of different, but mutually reinforcing interests (political and economic, respectively). The more the Minister promotes and eventually imposes optimization measures for all HSSCs in Quebec, the more commercial opportunities are created for consulting firms specializing in this sector; *vice versa*, the more consulting services proliferate in this field, the idea this Minister is identified with and centred his whole mandate on is legitimized and fulfilled. A political market for a new idea without a related economic market would not allow an idea to diffuse in a public context like the one of health care in Québec; similarly, with the sole existence of an economic market (like consultants’ offer and demand of training on lean management in health care), without any support of a strong political willpower, a new idea could still be promoted and would diffuse, but certainly with less success.

We argue that a second dynamic lies in the ability of lean management theory to mobilize different, yet converging and reinforcing interests – namely, political and economic ones. It is this dynamic of interest in lean management that particularly allowed for and enhanced on a larger scale the commodification of this discourse.
Dynamic of formalization: co-presence of materialization and rationalization processes.

Finally, the *engineering* mechanism is defined as the incorporation of a theory's principles into concrete tools, techniques and procedures (Cabantous & Gond, 2011). A form of engineering of lean management discourse is the appearance in the Quebec health care system scene of technical language (e.g. "kaizen", "Six Sigma", like for example in the press, in the Minister’s public speeches and in the title of the ministerial call for optimization projects itself: "Lean Six-Sigma"), the toolkit of process mapping, flow analysis, and the like, as present in the contents of consultants’ presentations and in the widespread diffusion of blogs and forums on line on lean management in health care in Quebec. In the same vein, the proliferation of “optimization projects” in the operating and emergency rooms of a growing number of HSSCs in Québec, as continuously reported in the press, can be seen as a form of incorporation of lean management discourse into concrete initiatives.

At the organizational level, we saw evidence of engineering in the trajectory of Kappa, as the discourse of optimization was immediately linked to localized initiatives that were in part already there, while in turn structuring new initiatives too, conceived within an optimization framework altogether. We saw engineering taking place in Omega’s trajectory too, as the initially generic optimization discourse started to become more concrete both in the language employed and in the articulation of specific projects and tools.

In all cases, this apparent incorporation of principles into tools (like specific projects, technical language, standardized procedures), is not the result of a straightforward and unidirectional process. In fact, two processes can be distinguished: an actual materialization of the optimization discourse into practices, and a discursive act of *ex post* labelling of work practices and tools already in place. We argue that both processes can be at play simultaneously: engineering by materialization of a theory into tools and engineering by rationalization of already espoused work practices. A discourse has some agency in that it certainly creates a reality, even a material one, but it is also a resource that can be purposefully mobilized to label or re-label an existing reality, for example for legitimacy purposes. Moreover, not only can the two processes act in parallel, but they can even mutually feed and complement each other. Indeed, if engineering were given exclusively by a one-way materialization of a set of ideas into tools and new practices (e.g. if lean management in health care were constituted by brand new standard operating procedures only, like 5S), we might expect the change to be of limited scope with the surge of a legitimization problem, as mismatch between the new materialized practices and the already practices in use might arise. On the other hand, if engineering of a set of ideas
only happened through a process of *ex post* rationalization of already espoused practices (i.e. if the introduction of lean management in health care was characterized by a simple discursive change, a different way to name what people already do), no actual change in organizational practices and strategizing would happen. The creation of new practices from newly introduced ideas requires simultaneously a retrospective inscription of old practices within the new concepts to be legitimized; *vice versa*, an *ex post* relabeling of practices that were already there should be coupled with the creation of new practices too for a real change to occur.

Therefore, a third dynamic lies in the ability of lean management theory to be, at the same time, materialized into new concrete tools and practices and mobilized to give a new name to those already existing. It is this dual affordance that allows the incorporation of principles into tools. We argue that it is this formalization dynamic that eventually reinforces the engineering mechanism itself.

**DISCUSSION**

In the two previous sections, we have provided evidence to document how lean management, as a set of concepts, is performative in the Québec health care sector. We have shown how lean management has appeared as a theory, launching and gradually establishing a series of practices, which have contributed to giving a new orientation and to partially reshaping the health care sector. By triggering a diversity of interventions by actors as diverse as physicians, workers’ unions, consultants, journalists and health care Ministry, lean management was able to move from being a proposed and proven managerial approach to improve efficiency in the delivery of care to a quasi-obligation and all-encompassing management philosophy. The performativity lens has allowed us to study not only the growing popularity of lean management discourse, but also how this discourse has begun to give rise to a new practical reality for the management of health care organizations.

More fundamentally, the notion of performativity re-specifies the relationships between theory and reality, proposing that theories do more than influence reality: they participate in *making* reality. Seen in this light, lean management as a theory is not limited to an abstract state, distinct from reality where it could simply be “applied”: it directly and actively participates in the phenomenon that starts to emerge in the sector – in our case, in a possible and partial transformation of the Québec health care sector. This transformation should be seen simultaneously as the core argument justifying the introduction of lean management and the
fundamental trigger for what we have described over the previous pages. For the contextual
reasons we have detailed, and via the dynamics we uncovered, lean management is actualized by
and in a number of practices. In turn, these practices contribute to reinforcing the status of lean
management and to enhancing its prevalence, with the end result of strengthening its “grip” over
the sector. Taken together, all the elements that we have presented in the previous sections can
be seen as performing lean management – albeit imperfectly, given the complexity and the size
of the sector. Through their accumulation over time, new subjects, new objects and new ways of
talking and thinking about the sector are being constituted. These effects make lean
management ideas progressively more present, visible, noticeable – in other words, they each
contribute in making it real for the actors involved in this world. However, the partiality of this
process should be underlined: the specific story we have been following is still emerging, and
should be understood as one attempt among many others possible at transforming and
reshaping the Québec health care sector. The extent of the success of such an endeavour remains
to be seen.

Even if the consequences of the irruption of lean management in the Québec health care sector
are still unclear, the fact that lean management was located by key actors between the actual
(and problematic) state of the sector, and the ideal state in which it should be has been
instrumental in setting the whole sector in movement. As explained, lean management was from
the start defined as a solution to the problems identified in the sector, especially by the Minister.
It was therefore cast as the vector of transformation needed in the sector.

A first contribution of this paper lies in the identification of a set of dynamics that act as the
processual conditions to start and maintain the performative cycle. Indeed, building on
Cabantous and Gond (2011), we propose that recursive movements at the heart of
performativity happen via a number of distinct dynamics. The dynamics we have identified are
not generic dynamics that could be found in all cases of performativity, but are specific to our
case; such dynamics have therefore to be investigated in each study of performativity. These
dynamics should be viewed as elements that have propelled, that are sustaining and that could
even inhibit the performativity of lean management. The double-sided nature of the three
dynamics we have uncovered explains why lean management continues over time to move from
a set of concepts to instantiation into specific practices that enact it. In this context, any
weakening of one side could affect the cycle of performativity. Therefore, identifying these
dynamics is important in understanding both what sparks, fosters and hinders the process of
performativity.
Furthermore, our case also opens the door to a reflection on another key element closely associated to performativity: the importance of movements between theory and reality, and back. If, following Law (2009), performativity implies that theories enact practices which then create a reality resembling the theory, there is also a second movement going from the practices back to the theory. As our case shows, the appearance of practices is accompanied by a process of evaluation of these practices and their effects with what the theory suggests. This evaluation process is important as it allows actors to align what they are doing more closely with the theory, to verify if what they are doing is in line with the theory or even to dismiss the theory and abandon it; we could also imagine that the theory itself can be adjusted, corrected or enriched via this evaluation process. In our case, we found evidence of this process whenever actors compared what they were doing with what they thought lean management was or with what it should be. For example, in both Kappa and Omega, there were instances where local actors discussed and debated if a project was really lean or not (see table 4), revealing not only that the idea of what lean management is had entered in their knowledge and vocabulary, but that it was also being used as a way to evaluate the degree to which what they were doing fitted with how they understood lean management. Another illustration of these processes of evaluation is one line of thinking found in some consultants’ discourse and presentations, as well in some physicians actively involved in lean management, namely the opposition between “doing” lean and “being” lean – where the latter was deemed the “only real” way of making use of the lean management’s ideas. This opposition was often invoked in a way to indicate how far most of the Québec HSSCs were from becoming lean, and also as a rationale to strive for a better, deeper penetration of the lean concepts, through training of more local practitioners and better lean projects. These brief examples show that there is a recurrent process of comparing reality with the “true” lean management, the theory and concepts that it offers. Finally, criticisms addressed to how lean management was advocated and deployed in health care organizations can be interpreted as counterperformative efforts (MacKenzie 2005), efforts which aimed at delegitimizing the relevance of lean management in this sector. These efforts also aimed at untightening the grip of this theory over the field, by showing how little these ideas fit with the health care reality. But generally speaking, the fact that the players involved in lean management in health care engaged in such an evaluation process is also part of the performativity cycle: in order to happen, such an evaluation requires a reading of the reality guided by the framework proposed by the theory (its language, its criteria, its measurements) – an indication in itself that the theory has at least partially succeeded in creating new subjects thinking and acting on their world with its concepts and that it has partially transcribed itself in new objects that lend
themselves to this evaluation. This recurrent evaluation of the practices’ congruency with the theory is as much of a key feature of a performative cycle as the efforts of making the reality reflect the theory. Our study therefore also shows how essential this return from reality to theory is in the performative cycle.

Bringing it all together, Figure 3 illustrates this performative cycle between theory and practice: the underlying dynamics of performativity and the processes of evaluation.

CONCLUSION

As Denis aptly summarizes, “performativity always goes with a specific world it participates in establishing or in maintaining.” (2006:9). This idea can be transferred to our context: what is
this world that lean management – understood as a performative set of concepts – contributes to creating, in Québec's health care sector? Lean management, and its corollary of optimization, is about efficiency, reducing waste and reorganizing processes to do more with less; it promises these results. In the health care sector, marked by limited resources and budgets cuts, these promises resonate with the current context. Lean management offers practical ways to cope with the management challenges that these large and complex organizations need to cope with. To have a health care sector constituted of “optimized” organizations is the desired world – a world where the whole sector is continually optimizing – especially in the eyes of the Ministry of Health and Social Services, the body that is fundamentally in charge of all health care organizations in Québec. Faced with economic constraints, and under the initiative of a Minister who has himself applied with success this approach, lean management proposes solutions to what has become a problem for the Ministry: the performance of its organizations.

On a final note, the complexity of the story told in these pages highlights not only the strength of performativity, but also its fragility. As we have shown, in order to develop the ascendancy on the whole health care sector we have detailed, lean management required a myriad of elements, ranging from macro economical trends affecting public administrations to the presence of a diversity of actors pursuing different interests at the micro level. Moreover, it required that all these elements progressively resonated with each other: no isolated actor could have triggered this process by itself, however powerful he might have been. Even the Minister, the official head of the health care sector, could not have set this in motion on such a scale if it would not have been for the consultants already active in the sector, and for some convinced physicians and practitioners; the combination of hard and soft aspects in the lean management ideas was also pivotal. Yet, the fate of lean management – and the extent of the health care sector’s transformation into a lean health care sector – is far from being sealed. We suspect that any alteration in the dynamics could create a domino effect in the sector, reducing or even bringing to a halt the performative cycle. We may be witnessing the early stages of such an effect currently, since there has been a significant change in the health care sector over the last months: following a change of governing party in Québec in the 2012 fall, a new health care Minister has been appointed. Although this Minister has not discredited lean management, it has become apparent that it is not one of his key priorities, as was the case for the previous Minister. How will this affect the important dynamic of interests that has occupied a central place in creating and sustaining the performativity of lean management in the sector? For now, the performative cycle surrounding lean management is still holding on, as many of the practices listed in table 5 are still going on – but for how long? Can this change alter the course of lean
management in this sector, or is lean management theory being performed with enough resilience that it can withhold such a modification? Only time will tell.
References


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