UTS UNIVERSITY OF TECHNOLOGY SYDNEY

Framing and Valuing Cultural Heritage at Royal Prince Alfred Hospital

by Scott Andrews

Thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

under the supervision of Dr Stephen Schweinsberg and Associate Professor Linda Leung

Certificate of Original Authorship

I, Scott Andrews, declare that this thesis is submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the Graduate Research School, Management Discipline Group at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

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Someone once said a PhD is like a marathon: it requires commitment, focus and support, is filled with challenges and moments of doubt, but ultimately ends with satisfaction and a great sense of achievement. Doing a PhD with two kids under eight, a senior executive wife, a career change, the construction of a new house and in a COVID-19 world as a front-line worker is not a marathon. Marathons are easy.

No success or achievement occurs in isolation. Thank you to my wife for understanding that time is irreversible, and moments must be grabbed as they appear. Without her patience, love and support I may have been the PhD that never was. I thank my retired schoolteacher mother-in-law who read and offered advice on early Masters and PhD papers. I also thank my beautiful children and apologise for the occasional moments when Daddy was 'short' or not really listening. That thing in the back of Dad's mind was probably stuck at the front. My PhD is not just for me, it's also for you. If Dad can ride a snowboard, so can you, if Dad can do a PhD, so can you.

I'd like to thank my supervisors: Professor Christine Burton who initially took me on before retirement; Associate Professor Linda Leung, who has been with me from the start, and who read every single paper and thought bubble I produced; Dr Stephen Schweinsberg who would become my principal supervisor, and Professor Simon Darcy and Dr Ece Kaya. Thank you for all your time, encouragement, and support throughout this process. I would also like to thank Associate Professor Jane Mears for her endless and unconditional support.

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If ten years ago someone had said to me that I would become a PhD in organisational identity and cultural heritage I would have stared blankly. I've had a few 'moments' completing this thesis but for the most part have found it incredibly rewarding. I have honestly loved learning how to learn, learning about organisational theory, and furthering my knowledge of the world of heritage and history, which of course I love.

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List of Abbreviations and Acronyms

Name	Full Name
RPA	Royal Prince Alfred Hospital
Admin block	Administration building
Vic Block	Queen Victoria Pavilion
A Block	Prince Albert Pavilion
KGV	King George V Memorial Hospital for Mothers and Babies
NSW	New South Wales
SLHD	Sydney Local Health District
KPEC	Kerry Packer Education Centre
ICOMOS	International Council on Monuments and Sites
VMO	Visiting Medical Offer
AHD	Accepted Heritage Discourse
RMO	Resident Medical Officer
USyd	University of Sydney
CED	Central, Enduring and Distinctive
UNESCO	United Nations Educational, Scientific and Cultural Organisation
TEV	Total Economic Value
REDCap	Research Electronic Data Capture
CIE	Capital Infrastructure and Engineering department

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Abstract

Healthcare institutions like Royal Prince Alfred Hospital (RPA) in Sydney, Australia, are large complex organisations under increasing pressure to justify all financial and operational decisions, including the presence and use of organisational heritage. RPA Hospital operates from within infrastructure built across a 141-year history, containing a wealth of both cultural built and movable heritage located across its campus.

While cultural heritage is ubiquitous in society, and is widely researched and explored, the impact and value of organisational heritage specifically situated within a hospital like RPA is not understood. Further, while much has been written about cultural heritage, hospitals, organisational identity, and culture, no research has expressly linked and framed these organisational dimensions as organisational capital, nor has organisational cultural heritage been adequately researched and analysed. This gap in knowledge presents a novel field of research and provides for an opportunity to research and analyse material cultural heritage framed within a large public hospital.

The present study identifies a new field of inquiry focusing on the role of organisational cultural heritage as an identity and cultural medium, and a strategic tool within a large public hospital, and aims to answer the critical question: **What is the meaning and value of organisational cultural heritage to Royal Prince Alfred Hospital?** It does so through exploring organisational member perceptions of RPA heritage use and value. Through a qualitative research approach utilising principles of grounded theory, interview and focus group sessions were conducted involving 32 study participants. Data collected from these sessions were analysed and coded using NVivo-12 data analysis software. Through a reflexive process, codes were categorised and constantly revisited and refined during the coding process until seven sub-categories emerged. These sub-categories were merged into three core categories and themes: Member Value, Organisational Value and Management Complexities.

Key findings from these themes suggest that RPA Hospital is a site of tension and struggle in that organisational heritage presents both benefits and burdens to the organisation. RPA maintains strong connections to its history and heritage but strives to be innovative and a leader in the field of healthcare. Heritage has been demonstrated to positively assist staff identification with the organisation and with specific clinical streams and departments. Conversely, it has also been demonstrated to lead to feelings of exclusion and diminishment in staff. Heritage collection and development has, since foundation, been controlled by staff members in positions of authority and

power. Those positions were dominated by elite, educated men from white European backgrounds. Consequently, heritage across RPA has been interpreted by some organisational members as selective and representative of only a small cohort of hospital staff. Further to this, those staff in positions of power manipulated the discourse surrounding interpretations of heritage thus creating a selective narrative that defined what organisational objects could contain heritage qualities.

Other study findings that support notions of heritage as a process and a performative management tool are evident in participant responses to the deliberate and strategic placement of heritage across the organisational facilities. The mystique, prestige, and sense of gravitas engendered by material heritage engagement leads some staff members to experience an intangible unspoken need to be the best and to strive. Hospitals like RPA contain differentiated cultures and numerous identities that cannot be effectively reconciled due to their complex nature. The presence and use of material heritage across such an organisation adds to this complexity. It can assist in the development of common identities and a common culture, and it can act as a divisive organisational artifact further underpinning fragmentation and division.

Finally, the preservation and degradation of the RPA heritage buildings, spaces and statues contains negative as well as positive implications for the image and reputation of the RPA. Heritage was identified as posing numerous operational challenges to the hospital in that heritage aged infrastructure is, in many instances, not suited to modern healthcare facilities.

This research concludes that there is value in determining and understanding the heritage and history of a healthcare institution such as RPA Hospital. Understanding, acknowledging, and respecting the organisational journey, foundational stories, physical artifacts, and organisational memory, which are all demonstrated components of identity, culture, and image, together represent an opportunity to create organisational value. In essence, heritage and history are valuable organisational management tools that when used effectively can underpin an organisation and can be used to strengthen organisational values. When used ineffectively, can instead add to division across the organisation. Together, these findings contribute to the field of heritage and management studies providing further insight to the meaning and value of organisational heritage situated within a public hospital. There are consequences associated with the preservation and presentation of built and movable heritage, and these consequences offer both advantages and disadvantages to the organisation that is RPA Hospital.

Chapter One: Introduction

This thesis presents a qualitative study into organisational cultural heritage at Royal Prince Alfred Hospital in Sydney, Australia. Through one-on-one interviews and focus groups, ideas and concepts surrounding hospital material heritage are explored and discussed by staff members and hospital volunteers. How cultural heritage is used by staff and volunteer members, the ways in which it is engaged with across the organisation and the complexities surrounding the presence of heritage within a modern healthcare facility are also examined.

The purpose of this chapter is to briefly outline the area of research, to explore the nature of organisational cultural heritage and to outline the structure of the thesis.

Study Context

Heritage is ubiquitous in society both in cities and across the urban landscape. A walk through the streets of Sydney and its surrounding suburbs will reveal endless heritage listed buildings, monuments, commemorative plaques, walking tours, entire heritage landscapes and precincts, and endless government and private museums and galleries that each showcase and celebrate the past in the present. Acts of preserving 'material objects and structures that come to us from that past, and making decisions about how we should treat them as something that matters to us collectively, is essentially a very modern idea' (Carman 2012, p. 13). Collecting and preserving material objects are Euro-Western expressions of value (Munjeri 2004), and these values reflect those qualities most associated with that heritage, which in itself is a contested concept long evolved in formation of meaning and in its application (Smith 2006; Waterton & Watson 2015).

Heritage is argued as 'one of the key characteristics of the culture in which we live' (Carman 2012, p. 13), and is 'concerned with the ways in which very selective material artifacts, mythologies, memories and traditions become resources for the present' (Graham 2002, p. 1004). Organisational heritage consists of those same components but as situated within the framework of a specific organisation (Balmer & Burghausen 2015d). Walking south down Missenden Road in Camperdown, New South Wales (NSW) a person will find the same diverse material heritage types located in every direction. One will find several Victorian era built colleges, the University of Sydney, itself an entire heritage listed precinct, and the Royal Prince Alfred Hospital (RPA), one of the oldest and largest public hospitals in Australia (Doherty 1996). To the left of Missenden Road at RPA sits the 1882 built NSW heritage listed Administration block and Queen Victoria Pavilion, replete with 100 year old statues and marble plaques. Sitting adjacent to these are large modern graphic heritage image

installations and interpretive signage with digital QR codes detailing a hospital walking tour. To the right of Missenden Road resides the City of Sydney Council heritage listed King George V building with its numerous granite and marble statues, terracotta reliefs and another walking tour interpretive sign. A walk through the buildings across campus will further see material heritage positioned in both old and new areas of the facility. Heritage is inescapably present and in active use in every direction across the Hospital. This is not uncommon within medical organisations and healthcare facilities as many are large government organisations with long histories.

> One hundred years ago the business of government was one of the biggest enterprises in the country. We can see the legacy of that activity all around us: post offices, police stations, court houses, railways, roads and bridges. Not surprisingly, much of the significant heritage in NSW is owned or managed by State government agencies. (Office of Environment and Heritage 2010)

How heritage is collected, preserved, and presented varies from organisation to organisation. There are numerous methods and various strategies applied to heritage use and management. Some organisations maintain and nurture heritage across the organisational space via wall hung objects including paintings, prints and maps, or in glass displays and through art installations. Others preserve and present their cultural heritage as gardens and spaces with sculptures and statues, or through cultural built heritage and architecture. Heritage and history are also protected and celebrated through museums, galleries, and archival collections, making it available and accessible to both organisational members and the general public. Many organisations now use and promote heritage through digital mediums, virtual displays and other multimedia platforms (Vassiliadis & Belenioti 2017). The recent expansion of digital social media platforms has enabled the development of an online presence that propels cultural heritage (Liang et al. 2021; Wang et al. 2021), museums and galleries (Marakos 2014; Marino et al. 2022), and corporate heritage (Sacco & Conz 2023; Ukpabi & Karjaluoto 2017) to wider audiences beyond the immediate organisational and local community member.

Such examples of digital heritage use are demonstrated by the Royal Adelaide Hospital Heritage Office. The Heritage Office maintains a digital online collection titled The Health Museum, and also manages the Health Museum of South Australia (Central Adelaide Local Health Network 2023). It preserves and showcases collections from the Calvary North Adelaide Hospital, the Queen Elizabeth Hospital, and the South Australia Dental Historical Society. Royal Perth Hospital, opened in 1855,

operates a museum which serves as a research facility for the Hospital and general public. The Royal Perth Hospital Museum and wider campus highlight not only cultural heritage associated with the Hospital's history and development, but depicts the wider social development of the City of Perth (East Metropolitan Health Service 2020). Sydney and Sydney Eye Hospital, the first and oldest hospital in Australia, located on Macquarie Street since 1811 (Watson 1911) celebrates its history and heritage across the facility, and through The Lucy Osburn-Nightingale Museum collection. The eye hospital's website landing page opening paragraph reads:

> Sydney and Sydney Eye Hospital is steeped in history, with a legacy of nursing and medical firsts to its credit and has paved the way in many clinical areas - both nationally and internationally (South Eastern Sydney Local Health District 2023).

Concord Repatriation General Hospital in NSW maintains a small, centralised nursing museum preserving and displaying the history of nursing at the Hospital with statues, reliefs and historical installations located across the campus. RPA also has a museum that preserves and displays material heritage including material from other operational hospitals managed by the district. This includes material from Concord Repatriation General Hospital, Sydney Dental Hospital, Canterbury Hospital and Balmain Hospital, and material associated with the now demolished Rachel Forster Hospital, Marrickville Hospital, Western Suburbs Hospital and Callan Park Hospital for the Insane.

Heritage collections and use of heritage however is not limited to government organisations. The preservation and use of heritage by non-government organisations in Australia is diverse. Telstra maintains heritage collections in Brisbane, Sydney and Melbourne (Berry 2022; TelSoc 2020). Private medical collections include the Harry Daley Museum at the Australian Society of Anaesthetics (Australian Society of Anaesthetists 2023), and the Old Coast Hospital in Little Bay, Sydney (Prince Henry Hospital Trained Nurses Association Inc. 2023). Sporting museums that collect and preserve memorabilia are also widespread and include the Australian Sports Museum at the Melbourne Cricket Ground (The Melbourne Cricket Club 2023), the Australia Tennis Museum (Tennis Australia 2023), Sydney Cricket Ground Museum (Sydney Cricket Ground 2023), and the Rugby League Museum (National Rugby League 2023). Rugby Australia have announced plans to develop and launch a new Rugby Union Museum to coincide with the 2027 Rugby World Cup (Williamson 2021).

Through actively developing and managing heritage collections and built heritage, these organisations are acknowledging value in their past. Further, a growing number of private sector and

government organisations are recognising the importance of their organisational heritage and are emphasising their history as a key component of their organisational identity (Iannone & Izzo 2017). There has also been an increase in the development and use of corporate and organisational museums, galleries, and heritage collections as marketing devices within corporate and organisational branding and identity strategies (Piątkowska 2014, p. 27). These actions function as an organisational strategic management tool that serve and operate at numerous levels within an organisation (Bonti 2014). From a management perspective, narratives derived from organisational history and heritage offer an internal social function from which the history and memory of the organisation is preserved and told (Bonti 2014). From a branding and marketing perspective, heritage is leveraged to emphasise organisational differentiation as a source for competitive advantage (Sacco & Conz 2023). By sustaining connections to the organisation's past, these actions serve to strengthen organisational identity and support organisational culture, which in turn provide pathways for organisational member connectedness and unity.

Understanding the nature of organisational culture and identity within large public hospitals like Royal Prince Alfred Hospital, the organisation under investigation in this thesis, is extremely important. Large public hospitals are recognised as unique complex organisations (Drucker 2012), often with multiple subcultures and identities, distinctly shaped and structured like no other organisational environment (Fajardo-Ortiz et al. 2015). This already complex environment is further complicated at RPA due to the operational nature of the organisation being situated in and across infrastructure first built in 1880. RPA has undergone many physical changes during its 141-year history, however many original buildings still exist and are occupied by staff in 2023. This makes this hospital and organisation unique in that it is both a hospital and a heritage organisation, actively collecting, preserving, and using its organisational heritage. RPA is on one hand a large modern quaternary research hospital, and on the other, a living heritage site.

RPA employs over six thousand staff members across multiple organisational levels and departments. A significant proportion of staff have spent a large percentage of their professional lives employed at the Hospital, or within the wider SLHD in which the Hospital resides. Some staff members graduated from school or university, found employment at RPA or within the wider district, and have never left. Others move between healthcare facilities and experience a range of employment positions. Such deep connections require direct investigation if a full and complete understanding into how organisational members perceive the presence and use of organisational cultural heritage.

While much has been written about cultural heritage, organisational identity and culture, little research has expressly linked and framed these organisational dimensions as organisational capital. Exploration has occurred in the fields of corporate heritage (see Balmer & Burghausen 2015a; Balmer 2017; Balmer & Burghausen 2019; Brunninge & Hartmann 2019; Cooper et al. 2015; Riviezzo et al. 2021), organisational identity and memory (see Balmer & Burghausen 2015b, 2015d; Urde et al. 2007), and corporate museums (see Bonti 2014; Carloni et al. 2023; Riviezzo et al. 2022). These areas of research are however focussed on corporate heritage within 'for profit' private enterprises or at universities as a branding and marketing tool. Heritage is used to sell products or services through communicating 'corporate identity in order to promote attraction and loyalty' (Bulotaite 2003, p. 450). Heritage preservation and use extends well beyond these frameworks of research and understanding as they do not account for organisational member engagement. They are components of largely outwardly facing strategies aimed at furthering consumer engagement. They do not account for nor offer any insight into heritage impact and value as situated within not for profit and government organisations like a public hospital.

Having a heritage however 'does not in itself create value, only the opportunity to do so' (Urde et al. 2007, p. 11), and as such, few organisations adequately investigate and recognise the value heritage represents to organisational culture and identity, or how it can be operationalised as an internally directed strategic asset. They do not understand how heritage is perceived and valued by organisational members. While heritage management instruments and conservation guidelines often protect and support organisational built heritage, they fail to account for the collection, preservation, and use of movable organisational heritage. The maintenance and management of heritage requires active interest and engagement by organisational members, regardless of heritage management policies and guidelines. Further, it requires an investment of resources that has implications for the organisation. Public hospitals are consistently forced to compete for resources (Esposito 2017) and so must justify their activities as value-oriented actions.

Through active allocations of resources and considered management of heritage, organisations like RPA have converted their physical artifacts and documented histories into symbols and useful organisational capital. Organisational capital being the accumulation and combination of organisational capabilities and resources along with the organisational policies, structure, processes and behaviour (Lev & Radhakrishnan 2003). Organisational capital is 'knowledge that doesn't go home at night' (Mouritsen & Koleva 2004, p. 178) that 'enables tangible and intangible resources

such as machines, patents, brands, and human capital to be productive' (Lev et al. 2016, p. 4). Lev et al. (2016, p. 4) argue that organisational capital is the prime intangible asset available to an organisation. Heritage is then a key 'value-contributing' asset central to an organisation differentiating itself within a given market or environment. Therefore, understanding how heritage functions within a hospital setting, and understanding how it is perceived, used, and valued by organisational members will determine the extent to which it contributes to RPA's organisational capital. Further, understanding the value of that heritage to a unique organisation such as RPA Hospital, under continued financial stress and with a very specific social function, is unknown.

This gap in knowledge presents a novel field of research and provides for an opportunity to research and analyse material cultural heritage framed within an organisational setting. The present study identifies a new field of inquiry focusing on the role of organisational cultural heritage as an identity and cultural medium, and a strategic tool within a large public hospital, and aims to answer the critical question: ***What is the meaning and value of organisational cultural heritage to Royal Prince Alfred Hospital***

Research Aims and Objectives

The aims of this study are to:

1. Explore the impact of material heritage on the culture and identity of Royal Prince Alfred Hospital.
2. Examine the non-economic value that material cultural heritage offers to Royal Prince Alfred Hospital.
3. Explore staff and volunteer member perceptions of value surrounding material cultural heritage.
4. Explore how organisational members engage with material heritage across the organisation.
5. Explore the implications of the presence of material heritage and the challenges it presents to the Hospital.
6. Offer recommendations for future research, policy, and practice.

Research Approach

To effectively address the research question and these aims surrounding the perceptions and value of heritage at Royal Prince Alfred Hospital, a qualitative approach based on the grounded theory method involving one-on-one interviews and focus groups was performed. Data were coded into groups and categories for analysis using NVivo-12 software to develop a theory grounded in the results. The conclusion and discussion of the data draws upon a number of frameworks within the organisational management studies and heritage studies literature to add additional context and meaning. These have been outlined in the literature review in Chapter Three.

Thesis Outline

This thesis consists of six chapters which outline the theoretical and methodological underpinnings of the study, explore and analyse the data, detail emergent findings, and conceptualise implications.

Chapter 1:
Chapter 1 introduces the core themes and aims of the study. It presents the field under investigation, outlines the research area, and identifies the gaps in the research on the value of heritage to hospital organisations and the implications of that heritage as perceived by organisational members. Further, it explains the research approach and methodology adopted.

Chapter 2:
Chapter 2 introduces and explores the nature and character of Royal Prince Alfred Hospital. It then looks at RPA's interesting and unique foundational story. The catalyst for construction of RPA occurred as a result of the attempted assassination of Prince Alfred, Duke of Edinburgh. The Hospital opened in 1882 and would develop and expand over the next 141 years collecting and preserving material heritage including built and movable heritage. The chapter concludes with a discussion about the diverse types of material heritage and then explores the ways in which the organisation uses heritage across the RPA campus.

Chapter 3:
Chapter 3 explores the literature on cultural heritage, organisations, cultural and identity and modern conceptions of organisational cultural heritage. Hospitals are unique organisations with numerous systems, functions, purposes, and people. They are also complex adaptive systems with complex identities, cultures, and subcultures. Organisational culture and identity literature is explored broadly and as situated within a hospital environment. Conceptions of cultural heritage are

then examined including a brief look at heritage management instruments and frameworks of understanding that led to modern Euro-western conceptions of material heritage, and socio-cultural and economic value perceptions. This is followed by a discussion surrounding the nature and meaning of organisational material artifacts, and material heritage as organisational symbols and actors. The drivers behind the active collection of this material are then explored as collecting and preservation is an expression of value and is therefore germane to this thesis. The chapter closes with a brief exploration of the challenges faced by modern healthcare facilities and the continued management of heritage.

Chapter 4:

Chapter 4 outlines the research methodological approach, the research paradigm, ontological and epistemological perspectives and the research design and data collection. It begins by outlining the rationale behind the use of qualitative research methodology and the grounded theory method of data collection and analysis where data collected is grounded in the field from which it is derived. The chapter then outlines the complexities surrounding the principal researcher's insider position within the organisation under investigation to explore researcher and study bias and explains the ethics application and various steps required to undertake the study. The methods undertaken during the research are then explained including the use of cultural probes as interview and focus group stimulants, as are the processes that were followed during the thirteen interview and three focus group sessions. An exploration of data analysis using NVivo-12 software and the coding strategy follows this, describing the coding process and the constant comparative analysis required to refine the raw transcript data in child codes that were merged into sub-categories and then into core categories or substantive themes.

Chapter 5:

Chapter 5 presents and analyses the data that emerged from Chapter four. The chapter begins by revisiting the primary thesis question and briefly reiterates the conceptual process used during data coding. The sub-categories and substantive themes are then described and explored demonstrating the process taken and rationale behind the emergence and construction of study key themes. Tables and graphs are used to highlight the nature of each sub-category and core category, to illustrate child node examples within each sub-category and to demonstrate interview and focus group session core category coverage. Seven sub-categories were constructed as a result of child node convergence that were then identified as belonging to three key core categories or substantive themes: **Organisational Value**, **Member Value** and **Management Complexities.** The chapter then

explores and critically analyses each of these seven sub-categories through the words of study participants.

Chapter 6:

Chapter 6 begins by revisiting the research problem and the field under investigation. It then discusses the key research findings, explores the deeper implications of the study results, situates them within the fields of organisational management studies and heritage studies, and considers the contribution it makes to those fields.

Chapter 7:

Chapter 7 explores the implications for policy and practice offering ideas towards the future management and use of heritage at RPA. It then examines the study limitations, offers areas for future research, and closes the thesis with a conclusion surrounding the meaning and value of heritage at Royal Prince Alfred Hospital.

Conclusion

This chapter has introduced the concept of organisational cultural heritage and has demonstrated that heritage is present and actively conserved and used by both public and private sector organisations. Rarely explored and poorly understood, organisational cultural heritage is an organisational asset that is engaged with daily by organisational members. As such, a case has been presented for research into the meaning and value of heritage, and the organisation under investigation in this thesis is that of Royal Prince Alfred Hospital.

The next chapter, Chapter 2, is about the institution at the centre of this thesis – RPA Hospital. It will explore the organisations foundation and subsequent development, ongoing management and use of material heritage and organisational history.

Chapter Two: Royal Prince Alfred Hospital

Introduction

This chapter examines the foundation story that led to the development of Prince Alfred Hospital, the relationship with the University of Sydney, and the ensuing values and goals that emerged as a result and that were supported during the growth and expansion of the Hospital over the following 141 years. It then explores the various types of built and movable material heritage located across the campus, and critically examines how it has been used by the organisation.

The Foundation of Prince Alfred Hospital

Royal Prince Alfred Hospital's foundation story has provided a central narrative that has underpinned the Hospital's identity and image from establishment. The story began on 12 March of 1868 with the attempted assassination of His Royal Highness, Prince Alfred, Duke of Edinburgh. While enjoying lunch at Clontarf, NSW, on the first royal visit to Australian shores, the Duke was shot point blank by Irish radical Henry James O'Farrell (Illustrated Sydney News 1868). The injury was only a flesh wound, and the Prince quickly recovered, however the incident was met with shame and indignation across Australia and throughout the British Empire (McCreery 2013). Such was the horror surrounding the event, that it is estimated 'around 250 indignation meetings [were] held in the weeks following the attempt on Prince Alfred's life' (Pentland 2015, p. 64). Indignation meetings allowed colonists to express their 'intense sorrow and indignation' in protest form surrounding the attempted assassination (Illustrated Sydney News 1868).

Embarrassed, Sydney residents sought a way to celebrate the Prince's recovery and decided on the erection of a permanent monument in the form of a new public hospital. A public subscription was launched to raise funds for its erection. The Prince Alfred Hospital Committee was formed to collect and administer the money (Young & Young 1984), and the Prince Alfred Memorial Fund was established (Government of New South Wales 1873). In five months, £22,000 was raised toward building what was to be called the Prince Alfred Memorial Hospital (Schlink 1933). In 1873 a Bill was passed by NSW parliament and adopted as the Act of Incorporation of the Prince Alfred Hospital. This marked the first step towards the Hospital's construction.

Integral to the development of the new Hospital was that of the Prince Alfred Hospital Committee's vision. The committee intended that the Hospital would 'take its position as the leading hospital of

the colony, and therefore be so designed as to provide for the ever-growing requirements of an increasing population' (Epps 1918, p. 20). From conception, RPA was intended as an innovator and a leading institution for the colony of NSW as a 'modern construction with improved arrangements' (Epps 1918, p. 20) 'possessing all modern appliances necessary for the effective treatment of disease' (Epps 1918, p. 8). The Hospital would be the 'largest in the southern hemisphere, the most modern and up to date' (Royal Prince Alfred Hospital 1904, p. 3), with the newest medical, architectural, administrative and workforce innovations adopted from overseas (Royal Prince Alfred Hospital 1927a). Further to this, Alfred Roberts contacted Florence Nightingale in 1868 seeking advice regarding the layout of the Hospital and nursing arrangements as her Nightingale system of nurse training, methods and practices were considered the best in the world (Armstrong 1965; Doherty 1996). She responded by sending copies of her book 'Notes on Nursing' and 'Notes on Hospitals', with the Prince Alfred Committee then making 'several alterations in their first plans in order to carry out her ideas' (Armstrong 1965, p. 20).

The sum of money raised through the public subscription was also significant in another way in that it had come from people of 'all shades of religious opinion and belief' (Government of New South Wales 1873, p. 26). As a result, it was decided that the institution would be unsectarian in character. Clause 10 in the Hospital's Magna Charter proposed the exclusion of clergy from the Hospital's directorate thus ensuring 'sectarian influences in the management of charitable institutions' were prevented (Epps 1918, p. 17; Government of New South Wales 1873). This was in line with growing social changes at the time. The NSW Legislative Council abolished the Church Act in 1862 which provided state funding for protestant and catholic churches (Chavura et al. 2019), and by the end of the 19th century 'free, compulsory, and secular schooling was established, and the federal Constitution set out principles for church–state relations'. Religion was in decline and as O'Farrell (1962, p. 133) argues, 'the growing forces of democracy and socialism' were to blame.

With this, the Prince Alfred Hospital would remain a true charitable general hospital open to people of all backgrounds 'without regard to class, creed or country' (Stephen 1882 in Armstrong 1965), or financial means. It would be a general one for the treatment of patients without distinction (Schlink 1956, p. 2). This was a significant step towards social inclusivity and increased social justice in a time of ongoing tensions in class, ethnic and gender relations (McCreery 2013).

The University of Sydney, itself less than 20 years old, had long desired for the construction of a medical school to train new doctors. The Faculty of Medicine had been established in 1856 but had

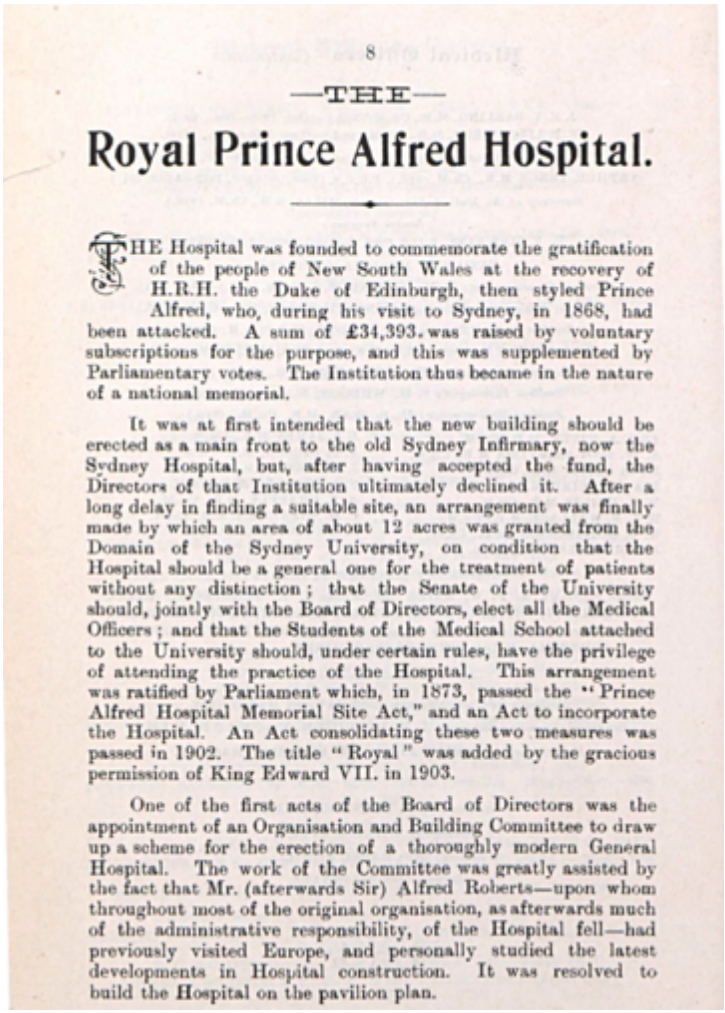
faced much resistance to the construction of a medical school (Winton 1971). The university made a recommendation to the NSW Government that 11 acres of university land at Grose Farm be offered for the construction of the Hospital. This land was offered on the proviso that the Hospital be made available to the Faculty of Medicine for teaching, and that it would be of a 'general character' (Epps 1918, p. 17). In other words, it would be a general hospital. A few acres of this allotment were to be reserved for the establishment of the long desired Medical School (Holland & Stanbury 1988).

In 1876 the foundations were prepared at Grose Farm, and in 1878 the stonemasons commenced construction. Four years later, on the 25 September 1882, The Prince Alfred Memorial Hospital opened with accommodation for 146 patients. All 140 were admitted that first day and over 1000 patients were treated by close of that first year (Prince Alfred Hospital 1882a). The funds raised for the Hospital were however not enough to build the original vision, and two planned wings were removed from the final design. Further, the Operations block was not complete upon opening and would be delayed until 1887 (Doherty 1996).

In that same year the New South Wales government also agreed to fund the construction of a medical school at the University of Sydney, the first in New South Wales (Winton 1971). The 1873 Act of Parliament that provided for the Hospital's foundation stipulated that a conjoint board consisting of the Hospital Board of Directors and the Senate of the university would together appoint medical staff for the Hospital (Blackburn 1948). This act proved a significant moment that would define the relationship between the Hospital and the university, and would henceforth frame and underpin the organisations goals and values moving forward, leading it to become Australia's leading quaternary referral teaching hospital, and a world leader in numerous areas of medical research (Sydney Local Health District 2017, 2023b).

Today, the story that surrounds the impetus for the development of RPA has evolved from one of embarrassment and shame to one that is commemorated as a milestone in the development of the colony of NSW (McCreery 2013). That the Hospital was funded by the community of NSW is central to the Hospital/community connection and to the culture and identity of RPA in that it has become a part of the legacy and heritage of the organisation. For the first fifty years the complete foundation story was to be published in the annual report (see Figure 1), and expanded upon as the Hospital story grew, until 1933, when the report was modernised in style and content. The story is then noted in the annual report foreword until 1971 after which is used sporadically during isolated stories or at major milestone events. This continued performance of remembering serves as a

reminder of the principles upon which the RPA was founded, and of the connection to the community that funded it.



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—THE—

Royal Prince Alfred Hospital.

THE Hospital was founded to commemorate the gratification of the people of New South Wales at the recovery of H.R.H. the Duke of Edinburgh, then styled Prince Alfred, who, during his visit to Sydney, in 1868, had been attacked. A sum of £34,393 was raised by voluntary subscriptions for the purpose, and this was supplemented by Parliamentary votes. The Institution thus became in the nature of a national memorial.

It was at first intended that the new building should be erected as a main front to the old Sydney Infirmary, now the Sydney Hospital, but, after having accepted the fund, the Directors of that Institution ultimately declined it. After a long delay in finding a suitable site, an arrangement was finally made by which an area of about 12 acres was granted from the Domain of the Sydney University, on condition that the Hospital should be a general one for the treatment of patients without any distinction; that the Senate of the University should, jointly with the Board of Directors, elect all the Medical Officers; and that the Students of the Medical School attached to the University should, under certain rules, have the privilege of attending the practice of the Hospital. This arrangement was ratified by Parliament which, in 1873, passed the "Prince Alfred Hospital Memorial Site Act," and an Act to incorporate the Hospital. An Act consolidating these two measures was passed in 1902. The title "Royal" was added by the gracious permission of King Edward VII. in 1903.

One of the first acts of the Board of Directors was the appointment of an Organisation and Building Committee to draw up a scheme for the erection of a thoroughly modern General Hospital. The work of the Committee was greatly assisted by the fact that Mr. (afterwards Sir) Alfred Roberts—upon whom throughout most of the original organisation, as afterwards much of the administrative responsibility, of the Hospital fell—had previously visited Europe, and personally studied the latest developments in Hospital construction. It was resolved to build the Hospital on the pavilion plan.

Figure 1 Royal Prince Alfred Hospital Annual Report, 1911, page 8 (Source: RPA Museum)

The historical legacy of RPA is one interwoven with notions of innovation and progression which are today perceived as a part of its tradition. A search of the RPA Annual Reports, Year In Reviews and local publications including the RPA Gazette, Pacemaker and HealthMatters newsletters see consistent use of language and articulations that associate the traditions and legacy of RPA with innovations, excellence and pioneering attitudes and behaviour. Whether it be discussing 'the pioneer members of the Royal Prince Alfred Hospital Auxillary' (Royal Prince Alfred Hospital 1929, p. 29), that 'our pioneer thoracic surgeons were training in Britain' (Royal Prince Alfred Hospital 1982a, p. 9), the 'widespread media coverage highlighting the pioneering work of staff throughout the CSAHS facilities' (Central Sydney Area Health Service 1997, p. 26), that 'the district pioneered the rollout of electronic medication management' (Sydney Local Health District 2015, p. 4) or it be a part

of a building logo (see Figure 2), the term pioneer is intentionally and aggressively associated with the history of RPA. Central to the story of RPA is the belief that 'since its foundation, 138 years ago, the staff at RPA have pioneered innovative techniques, treatments and complex interventions' (Sydney Local Health District 2021, p. 94).

Such language is repeated across the literature. RPA views itself as having 'a long tradition of pioneering within a research framework, across therapies, drug delivery, surgical treatment, diagnosis, disease management and disease prevention' (Sydney Local Health District 2020, p. 86). Use of the word pioneer to describe a contemporary organisation with significant heritage poses numerous implications. It encapsulates both the notion of RPA at the cutting edge of innovation, and being the first whilst it acts as a signal to a past founded on modern practices with 'modern appliances' (Epps 1918, p. 8). It builds a myth and legend, in line with other legends that stem from the Australian Victorian era which Hirst (1978) says 'encourages reverence for the past; celebrates individual rather than collective or state enterprise; and it provides a classless view of society since all social and economic differences are obliterated by the generous application of the "pioneer" label'. Of note is that RPA has repeatedly labelled individual staff as pioneers, staff collectively as pioneers, and the organisation as a whole as a pioneer.

Key to these, and many other declarations is the use of the word 'tradition'. The legacy of RPA is built on a 'tradition of excellence since 1882' (see Figure 3 and Figure 4) and a tradition of innovation.

> This cost-efficient increase in productivity was accompanied by a multitude of letters from patients and relatives praising both the high professional standards and kind personal attention which characterises care at Royal Prince Alfred Hospital and so maintains the Hospital's tradition of excellence.
> (Central Sydney Area Health Service 1992, p. 23)

> Awarded annually, the RPA Foundation Medal was established in 2000 to highlight and continue the Hospital's tradition of innovation.
> (Central Sydney Area Health Service 2001, p. 46)

> Sydney District Nursing is a core service of **rpa**virtual, building on a 121 year strong legacy of providing care in the community since 1900.
> (Sydney Local Health District 2021, p. 24)

There is a clear tension between RPA's identity as a place of tradition and heritage and as a modern innovator. RPA's identity is multi-dimensional in that notions of modernity, innovation and excellence are at the heart of RPA's foundation story and as such have become an integral part of its ongoing heritage. Early innovations included the inclusion of modern sewerage systems, light and air filled Nightingale Wards, connection to the first medical school in NSW at the University of Sydney, and construction of Gloucester House, the first Intermediate Hospital (public/private) in NSW.

On one hand the Hospital strives to be at the forefront, to be innovative and pioneering, whilst on the other espouses those strong connections to its past which have been cemented as immovable ideals integral to the identity of the organision. In this sense, it must continue to be innovative as this is its very heritage. These foundational values have been supported and preserved through the continued celebration of history and heritage at the Hospital across time and space. Further, the language and rhetoric that emerges from the Hospital in support of these ideals overtly flags them as non-negotiable to organisational members. These values are then strengthened by the presence and preservation of material heritage, which in turn ensures an ongoing connection to the original vision and purpose for the construction of the Hospital. They are also strengthened by continued innovation as demonstrated in the soon to be constructed Sydney Biomedical Accelerator and Sydney Innovation Precinct node of the new Tech Central, both significant aspects of the future development of RPA. A vision of providing healthcare to all people from the community, and a vision of being an institutional leader and innovative organisation which is deeply intertwined with notions of medical history and heritage.

Figure 2 IRO Building, Royal Prince Alfred Hospital (Source: Author)

Figure 3 RPA Logo Artwork (Source: Author)

Figure 4 RPA Historic Artwork (Source: Author)

The founding story would in time transform to become a saga continually retold at celebrations and hospital milestones throughout the years (see Prince Alfred Hospital 1882b; Royal Prince Alfred Hospital 1982b, 1983, 2007, 2022). Generations of clinicians and staff repeat the story with some celebrating a personal connection it, thereby connecting their person heritage to that of the Hospitals. The great-grandfather of Richard Waugh, a current RPA staff member, assisted in saving the Duke's life upon being shot. Junior surgeon Isaac Waugh travelled with the Prince on the HMS *Galatea* to Australia in 1868 and assisted in the operation on the Prince. Isaac Waugh went back to Britain with the Prince, only to return a year later to settle in Parramatta and start a medical dynasty eventuating in his great-grandson Richard becoming director of radiology at RPA today (R Waugh 2018, pers. comm., 18 December). Such stories are not uncommon. Many other medical and administrative dynasties exist in the Hospital's history which demonstrate the personal connections generations of staff and clinicians have with the Hospital, who in turn become a part of the larger heritage and history of the organisation.

Royal patronage has also closely figured throughout the history of the Hospital and has been remembered and celebrated through hospital publications and naming of buildings. Prince George and Clarence, sons of the Prince of Wales visited in 1887. Framed and dated portraits of both children adorn the RL Harris Heritage Room in the Kerry Packer Education Centre. The Operations block was renamed the Princes Block in celebration of the event. The Duke and Duchess of York visited the Hospital in 1901 to lay the Queen Victoria Memorial Building foundation stone. The tradition of naming buildings after the British Royal Family would continue into the twentieth century with the naming of Gloucester House, the King George V Memorial Hospital for Mothers and Babies, the Queen Mary Home for Nurses, and the Edinburgh Block after the Duke of Edinburgh.

The Administration Block that still possesses its original timber front door and stained glass transom now displays a modern 1980's etched glass image of the RPA emblem and royal coat of arms. In 1902 the Prince Alfred Hospital board of directors wrote to the British royal family and King Edward VII via the Governor General of Australia requesting the addition of the 'Royal' prefix to the Hospital name. This was granted in 1903 and the Hospital would henceforth be known as the Royal Prince Alfred Hospital (National Archives of Australia 1903). The 1903 annual report (p. 28) notes:

> ‘His Majesty the King [is] pleased to confer upon the Hospital the title Royal Prince Alfred Hospital in view of its long and intimate connection with the Royal family, in memory on one of whom it was founded. The distinction is naturally very highly appreciated by the board’.

The honour and prestige in which this is considered is further evident during the 1905 laying the foundation stone ceremony for the Nurses’ Home extension. Professor Anderson Stuart, chairman of the board at the time, reminds those gathered that ‘for it is now, by His Majesty’s gracious permission, a Royal Hospital – the largest hospital south of the line, and one of the best anywhere’ (Royal Prince Alfred Hospital 1905, p. 3), and the first hospital in Australia to be so honoured (Royal Prince Alfred Hospital 1927b). This distinction was clearly sought after and highly valued adding an additional layer of prestige to the Hospital. An emblem was then created utilising Prince Alfred’s coat of arms and crest that would thereafter be used as a unique symbolic reminder of the hospital’s continued connection to the British royal family. Further, such building naming’s has ensured the foundation story and British royal family association remains firmly connected to the Hospital across time regardless of campus redevelopments and new innovations. It supports those notions of the Hospital remaining connected to traditions and as such are significant status symbols.

Royal Prince Alfred Hospital Cultural Heritage

Royal Prince Alfred Hospital preserves a diverse range of both movable and built cultural heritage in and around the 29 buildings, with one museum and archives facility located on campus. These will be explored in more detail later in the chapter, however, to provide a framework for this discussion it is necessary to briefly outline this material. Notions of heritage in this thesis includes both that are formally heritage listed on government registers and those unlisted but are of perceived organisational heritage value. Built heritage at RPA includes the Morgue (1880) and adjoining Pathology Building (1905), the Administration Block (1882) and the Queen Victoria Memorial Building (1904), Gloucester House (1936), Engineering and Boiler Block (1936), King George V Memorial Hospital for Mothers and Babies (1941) and the RPA Chapel (1955). Movable heritage is diverse and ranges from marble, granite, bronze and copper statues to marble busts, artists portraits, several of which were Archibald entrants, bronze portrait reliefs, a fountain, furniture and numerous heritage framed images and certificates.

NSW Health Heritage Management Instruments

Like all heritage, these buildings and objects were originally conceived as modern innovative architecture and art, and through time have become recognised and valued as organisational heritage due to government frameworks and organisational member determination. In NSW, the Heritage Act of 1977 required government agencies to compile a register of heritage assets for protection on behalf of the community, identifying that they 'form an important part of our [Australian] identity' (Office for the Arts 2021). This Act would lay the groundwork for formally recognising built heritage at RPA as significant to the national identity. In 1981, the National Trust of Australia classified and listed several RPA buildings as 'essential to the heritage of Australia' as 'conveying the architectural and medical ideals of the era' (Royal Prince Alfred Hospital 1981). The National Trusts Register lists RPA buildings as a classified group or precinct, individually listing:

- The Administration Block
- The Victoria and Albert Pavilions
- The Medical Officers' Quarters, formerly the Nurses Home
- Gloucester House
- King George V Memorial Hospital etc (listing includes the artworks)
- Original wings to the 1876 hospital
- 1937 boiler house

(Department of Public Works & Services 1996, p. 146)

Although the National Trust holds no statutory power, this inclusion was significant and influential in that 'inclusion on the National Trust Register generally indicates a high level of community support. Insensitive redevelopment is likely to meet with community disapproval' (Department of Public Works & Services 1996, p. 146). This listing was further significant in that a review of the RPA literature finds the word heritage used for the first time in connection to this event. Prior to this, built heritage is referred to as RPA's 'historic and famous buildings' (Royal Prince Alfred Hospital 1974). The 1981 98th annual report is the first hospital document to acknowledge RPA as having heritage, and to celebrate it through three full pages of images and information detailing the newly listed heritage built environment (see Figure 5). This listing would be formalised with the 1987 Section 170 amendment to the 1977 Heritage Act which required 'each government instrumentality to prepare a heritage and conservation register of the heritage assets it either owns or controls' (Department of Public Works & Services 1996, p. 148). As a result, the Department of Health

prepared a Draft Heritage and Conservation Register. The following hospital buildings at RPA were listed:

- King George V Memorial Hospital for Mothers and Babies
- Gloucester House
- Resident Medical Officers' Quarters (formerly the original Nurses Home)
- The C and D Pavilions (however, these buildings had since been demolished and only a portion of the arcade remains).

(Department of Public Works & Services 1996, p. 148)

RPA's HERITAGE

Administration Block
The Foundation Stone of the Administration Block was laid in 1876 and the building completed in 1882. The Victorian design is attributed to Mansfield Bros. and is said to be based on that of St. Thomas' Hospital, London.
Traditionally the fulcrum of the Hospital site, the building contains a central lobby with marble flooring, elaborate plaster work to both walls and ceiling and several very fine stained glass windows, depicting the Royal Coat of Arms, Queen Victoria, Caritas etc. The rear of the lobby has a pressed metal ceiling and a Lyncrusta Art Nouveau dado. The southern side hall has a floor of very fine High Victorian tiles — probably the whole lobby floor was originally to this pattern.
The block has a basement and three upper levels. The chief facade to Missenden Road features very finely carved sandstone dressings to the cream brick facade. Red bricks emphasize the arched openings of the ground floor. Stonework and brickwork is of first quality. The facade is symmetrical about a three storeyed portico with grey granite columns, and a carved sandstone pediment. Mansard roof elements emphasize the various bays of the facade. Their original surface (presumably slate) has been replaced by terracotta tile.

Resident Medical Officers' Quarters
Opened in 1892, the Victorian design of the Quarters building is attributed to Mansfield Bros. and consists of three storeys above a basement.
The south and west elevations are all in original condition of late Victorian character with bays and verandahs massing up into a slate roof broken by picturesque gables, pediments and chimneys. The walling is of cream brickwork with sandstone dressings. Brick arches to the basement level support a single storey verandah to the entry level, whose railings are of cast iron in a rococo pattern.

Gloucester House
Designed by Stephenson, Meldrum and Turner and completed in 1936, the Early Modern design of Gloucester House consists of a seven-level structure following a basically 'L' shaped plan with wide north facing balconies providing white horizontal elements to the cream brick walling. The whole effect is streamlined with a feature seven-level curved bay at the eastern end of the building.
The entrance forecourt is very subdued, a turning circle centred on a sculpture of the Egyptian God Imhotep, the first known architect. Within, the streamlined lines extend to the entrance lobby ceilings and all wall junctions are rounded off. The stairs are cleanly detailed, with glass brick walls.
This building was the first thoroughly detailed example of the new European and new hospital design philosophies to be built in Sydney. Stephenson and Meldrum successfully transformed the nations hospitals over the next 20 years to this model.

King George V Hospital
Opened in 1941, to an Early Modern design by Stephenson and Turner, the seven above ground levels of this hospital are clearly expressed by the horizontal lines of the white balconies. There is careful massing of the wings about the central service core, which is given expression in the roof top plant room.
The walling is generally of cream brick.
The two eastern wings abut Missenden Road where they are clad in glazed terracotta tiles with featured panels of blue and cream terracotta depicting mothers and infants (after Della Robbia) by O.L. Steen. These two wings frame the entrance court. The entrance vestibule is defined by the porte cochere, a free form reinforced concrete slab, punctured by dome lights, and supported on circular columns clad in blue glazed terracotta. The vestibule is flush panelled in maple and the column ceiling, wall forms and light fittings show the streamlined style which extends throughout the hospital.
The three garden spaces to the east of the building contain sculptures in stone carved by Andros Maszaros between 1944 and 1946, and representing 'Maternity', King George V and 'The Surgeon'.
The rear elevation is austere; curved stair landings are expressed in walls of green glass brick.
The King George V Hospital represents a pinnacle in Stephenson and Turner's endeavours to introduce clean European styling and modern hospital design principles into Australia. That the design was eminently workable is evident in the very few changes made to the structure over the past 30 years.

Facades of Victoria and Albert Pavilions
Completed in 1904 to a design by the Government Architect, W. L. Vernon in consultation with Mansfield Bros., both pavilions have very handsome elevations, of three levels above a basement, fenestrated by regular banks of shuttered windows. The walling is of red brickwork with occasional stone dressings. Both pavilions are dominated by a projecting bay surmounted by a pediment bearing a copper clad statue of Queen Victoria (southern pavilion) and Prince Albert (northern pavilion).
Together with the Administration Block and allied treescape, these facades form an elevation to Missenden Road of considerable architectural interest.

Administration Block

Figure 5 Royal Prince Alfred Hospital Annual Report, 1981 (Source: RPA Museum)

Following this, in 1989 the Australian Heritage Commission which maintained the 'Register of the National Estate', now in archive, further listed Royal Prince Alfred Hospital and King George V Memorial Hospital for Mothers and Babies as 'places of significance' (Australian Heritage Commission 1989). It wasn't until 1996 however that the Asset Management Unit of the Department of Health commissioned the first 'Conservation and Management Plan' in conjunction with the Heritage Council of NSW and the Central Sydney Area Health Service (see Department of Public Works & Services 1996). The Australian ICOMOS Charter for the Conservation of Places of Cultural Significance (The Burra Charter) would serve as its primary reference and guide (Department of Public Works & Services 1996).

In 1999 the Administration Block (see Figure 6) and the Queen Victoria Memorial Building which includes the Victoria and Albert Block Pavilions (see Figure 7) were deemed culturally significant to the state of NSW and were formally placed on the NSW Heritage Register. These heritage management instruments, while catalysts for the protection and preservation of select built heritage, did not include the original Morgue, Engineering and Boiler Block, Gloucester House, King George V building or the RPA Chapel. There is no documented reason for this exclusion. These instruments failed to identify or list moveable heritage. The 1996 Conservation and Management Plan however did acknowledge that 'although the current Department of Health Register does not

reach this level of detail, the Hospital includes a number of artworks such as fountains and statues which should, in the future, be listed on a revised register'. To date this has not occurred.

Figure 6 Administration Building, RPA (Source: RPA Museum)

Figure 7 Albert Pavilion, RPA (Source: Author)

In 2021 a review of the NSW Heritage Act identified that out of the 1740 items in NSW listed on the register, that only 27 were movable heritage (Engineers Australia 2021). This figure is indicative of the unbalanced focus given to built structures deemed significant over movable objects that might be perceived as mundane and of less value. The Engineers Australia (2021, p. 6) report suggests 'this is more a reflection of the application of significance criteria and can be addressed through education of heritage practitioners'. It might also be suggestive of the strong desire or need to protect built heritage in lieu of constant demolition and redevelopment. This fact is evident at RPA as several buildings that were recommended for protection such as the C and D Block Ward Pavilions were demolished to permit redevelopment and expansion. This is further evident in 2024 with the planned demolition of the old Morgue and Pathology building, and the RPA Chapel. Pragmatic

decisions and limited space dictate the removal of these buildings to facilitate the expansion and modernisation of the eastern end of the health campus.

Formal policies regarding the management of movable heritage in NSW Health were first developed in 1979 (unavailable for access) and were rescinded and replaced in 2005 with the NSW Department of Health Policy on the Management of Moveable Heritage Items (PD2005_401), updated in 2010 (PD2010_029). In response to this document, in 2006 RPA released the Royal Prince Alfred Hospital Access To Archival / Historical Material Management In RPAH Museum (RPAH PD 2006_027_1), updated 2013 and 2018. This was replaced in 2023 with the SLHD: Collection Policy Compliance Procedure RPA Museum and Archives (RPAH_PCP2023_04) which strengthened language and positioning.

That the Hospital and wider district executive team support these policies and actively exceed them is evident in the numerous wall portraits, heritage images and furniture, and other objects of organisational heritage located across the Hospital campus. Movable heritage is celebrated by select and carefully considered placement in positions relevant to specific clinical or administrative services, or in positions that publicly celebrate people, places, or events. Heritage objects such as busts, portraits and stained glass windows have been donated to the Hospital to celebrate and commemorate events since opening in 1882.

> As a mark of their appreciation of the efforts made by the chairman (Professor Anderson Stuart), which have resulted in the erection of the new pavilions…the members of the honorary medical staff have decided to present his bust to the institution, to be placed in the main hall (Prince Alfred Hospital 1902, p. 6).

These donations continue today in the form of modern art (see Figure 8).

> Installed at the entrance to RPA Women and Babies, the sculpture was donated in honour of Alan's twins, Matthew and Elizabeth, born at King George V in 1976 (Sydney Local Health District 2019b, p. 7)

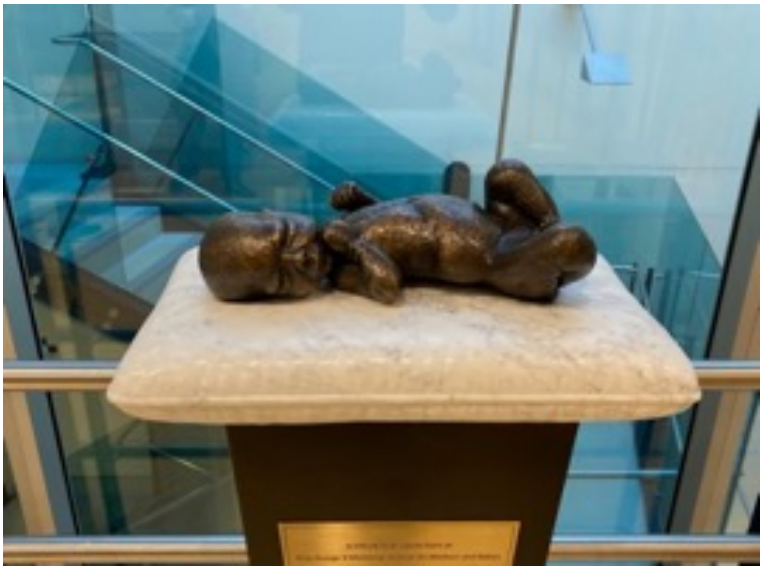


Figure 8 Bronze Baby (source: Author)

The conservation of movable heritage is first mentioned in the RPA literature in 1976, with the preservation of a clock (Royal Prince Alfred Hospital 1976). Notions of preservation however are demonstrated on numerous occasions across local publications. In a letter from the Palestine Branch of the RPA Medical Officers Association a doctor writes 'It was a most excellent dinner. I enclose a menu card which is worthy of preservation, I think in our archives' (Royal Prince Alfred Hospital 1941). Such acts of preservation and by extension, celebrations of organisational events, are clear expressions of pride in the organisation's activities and achievements. This menu card, signed by all RPA staff present, has remained on display in the RPA Museum for many years.

The Hospital archives, established with the opening of the Hospital, collected annual reports, publications and other assorted items including medical technology deemed significant for preservation. It would grow alongside a separate RPA archival collection commenced in 1933 by Sister Muriel Doherty:

> She observed that the Nurses Library had autographed copies of Florence Nightingales Notes on Nursing and Notes on Hospitals which had been given by Sir Alfred Roberts to the nurses in 1888. Miss Doherty recognised both the historic and intrinsic value of these books and persuaded Anthony Hordern to donate a small glass fronted cabinet to house them. This was augmented by copies of 1887 handwritten nurses journal, various certificates and nursing medals (Croll 1984, p. 2).

This collection, originally located in the 1892 Nurses home, would grow as nursing staff collected material significant to the history of nursing at RPA. In 1956 the collection would be relocated to the Queen Mary Nurses Home and formalised as the Gwendolyn Peg Museum of Nursing. Sister Peg was integral to the early management of RPA nursing memorabilia and would further assist in its management alongside other ex RPA Nursing and Medical staff volunteers as they collected material relevant to the history of RPA. In 2004 the nursing museum would finally be relocated the King George V building and expanded as the RPA Museum.

Heritage at RPA

RPA heritage features in every aspect of operations at the Hospital. From any external position on campus heritage buildings can be viewed. Wall hung artist portraits, heritage images and certificates are encountered walking through new and old corridors and spaces. Heritage furniture and other objects of organisational heritage value are replete throughout non-clinical spaces, and heritage styled spaces are carefully supported and maintained. Heritage imagery is featured as key components of the organisational image used in digital media campaigns, internal and external publications, and staff events.

Significant in this list of buildings is the Administration Block (Admin Block) which also serves as the main entrance located on Missenden Road. The Admin Block is Victorian Free Classical in style containing a three-storey portico with cream brick façade, sandstone embellishments, and grey granite columns (NSW Government 2000). It is the only remaining section of the original 1882 construction and is a key building and commonly used image in hospital communications. It is also the primary entrance to the Hospital, of which patients, staff and visitors must traverse through to access the facility from Missenden Road, Camperdown.

To the left of the front door sits the 1876 foundation stone. This stone is engraved with Latin script that translates as:

In gratitude to God most great and most high
who, when Alfred Duke of Edinburgh
had been seriously wounded by a fanatic
during the very holidays and rejoicing
during which the city of Sydney was welcoming him,

saved him for the Queen his mother and all the Britons.
The colony of New South Wales,
freed from the pain and disgrace of so great a crime,
founded this refuge of the sick
and home of healing
in the year of our salvation 1876,
while his Excellency Sir Hercules G.R. Robinson, G.C.M., was Governor of the Colony (Royal Prince Alfred Hospital 2007, p. 19).

This foundation stone and script serve as a verbal monument and powerful symbolic reminder of the cause for the Hospital's foundation, and of the Hospital itself as a living monument to the survival of the Duke of Edinburgh. It memorialises the events of 1876, thanking God for saving the Prince and relieving Sydney of shame, and presents a unified sanctuary for hope and healing. Further, it purposely and permanently connects the British Royal family to the people of Sydney though monumental construction. Paradoxically, there is no English translation with the foundation stone, and so it is unlikely those people 'without distinction', for whom the Hospital would care for, would understand the language of Latin and therefore the sentiment behind message. It is also conceivable that the Prince Alfred Committee and architects, the Mansfield Brothers, failed to perceive value in an English translation, but instead saw symbolic value in connecting the Hospital to a more distant colonial era through the stateliness of Latin.

Such contradictions further highlight the tension between a hospital striving to be the biggest and most modern with one attempting to retain connections to tradition, monarchy, and status. A significant part of that contradiction are those forces that exist between a vision and a reality. Both public hospital funding and public hospital reputations across time has been fraught with challenges (Dickey 2020; Palmer & Short 2000). General hospitals were hospitals for the poor and were subsidised by the government but were also required to self-fund financial shortfalls, often resulting in enough resources to remain operational, but not enough to grow and develop (Gillespie & Gillespie 2002). Further to this, investment in new infrastructure often placed the Hospital under financial strain. This is evident as early as 1882 in not having the funds to build the original vision of the Hospital and is evident on numerous other occasions where infrastructure such as the RPA Chapel and Gloucester House or hospital equipment went unfunded or was underfunded relying on numerous fund raising campaigns. The 1904 Annual Report lists several such funds including the Endowment Fund, Nurses Home Fund, Queen Victoria Memorial Fund, The Samaritan Fund, Hospital

Saturday Fund, and a Minor Bequests Fund. The 1984 annual report notes that expansionary activities have led to a short fall of serious proportions, 'which at the time of writing could well present a problem for the ensuring year' (p. 26). Consequently, the organisational identity struggles with a lack of resources, under the weight of expectations that espouse innovation and modernity in medicine and healthcare, and while relying on history and heritage to continue a narrative that at times was unsupported.

The foyer inside the Administration Block front doors displays six busts of men instrumental to the development of RPA. Male doctors figured prominently in the history of RPA and performed significant roles in its development and expansion. Female contributions to the establishment and early development of the Hospital were invisible and largely ignored or were minimally celebrated. This is indicative of a Victorian era patriarchal society, the hierarchical nature of hospitals and of the diminished value certain roles held at RPA. There is no documentation supporting the roles woman played in the establishment of the RPA other than that performed by the matron, the only esteemed female role. Other roles held by woman were that of nurses, kitchen, and laundry staff, the latter two for which there is no documentation regarding staff. Nursing was not considered a profession and so was not well regarded (Dingwall et al. 2002; Messer 1914). It was not until 1936 that Nursing was formally professionalised at RPA with the establishment of the Preliminary Training School (Armstrong 1965). Further, Dr Jessie Aspinall, the first female doctor to be appointed to a resident medical officers position at RPA in 1906 was dismissed after 10 days 'on the grounds that no woman was capable of carrying out the duties of a medical resident in a general hospital' (McCarthy 2005, p. 265). Although reappointed later after significant controversy and with the support of Professor Anderson Stuart, 'for some time she was still being called Miss Aspinall and not Dr Aspinall' (Armstrong 1965, p. 146). Such attitudes continued to influence hospital appointments for many years. When no men were available during the second world war, Dr Margaret Mulvey was appointed Medical Superintendent of KGV Hospital 'despite Bertie (Chairman of the Board Dr Herbert Schlink), who did not believe … [she] would last six months' (Hayes 1991, p. 9).

Although busts of men dominate RPA campus, there is one exception, that of Florence Nightingale, which once sat in the entrance to the 1956 Nurses' Home, until relocation to the Admin. Block foyer in 2014. Florence Nightingale was a key figure in the development of modern nursing in the 20th century and 'would lay the foundation for nursing as a profession' (Egenes 2017, p. 6). Nightingale was consulted by the Prince Alfred Hospital Committee member Sir Alfred Roberts regarding the design and construction of the RPA, and matters of nursing management and education (Doherty

1996; Godden 2006). These busts are purposely positioned in the heritage entrance foyer and are material reminders to staff, visitors, and patients of the long history of medicine and nursing at RPA, and of the strong association with the University of Sydney Medical School. Bradley (2002, p. 124) suggests that 'while monuments refer to a past they are often directed to a future'. Busts and portraiture used in this way can be interpreted numerous ways eliciting divergent views and interpretations. On one hand they are monuments to organisational history linking the present to the past. They present an image of institutional longevity and grandeur aimed at influencing those in proximity and serve as a concrete reminder to staff of whose steps they follow in. They seek to 'nudge' staff towards the pursuit of distinction and excellence as first established in the Hospital's Magna Charter. On the other hand, they are monuments of an era that was strictly patriarchal where woman were exploited sexually, physically, economically and socially (Yildirim 2015), and so serve as a reminder of that past. From this perspective, they are monuments to those select wealthy, educated men of white European descent considered worthy of recognition. They epitomise the social hierarchies and divided nature of Victorian era society.

Other attempts to promote organisational 'excellence' are evident through the display of awards and certificates across the RPA campus. Prominently wall mounting the 'Sir John Sulman Medal for Excellence in Public Architecture' inside the entrance to KGV expands those notions of distinction beyond medical and clinical streams to demonstrate excellence in other areas of the organisation (see Figure 9). Such strategic actions support a narrative developed and continually nurtured though the deliberate placement of moveable heritage across the Hospital buildings. This narrative has over time developed into a dialogue between staff, patients, and the organisational story. A dialogue that constantly reinforces notions surrounding culture, heritage, and organisational values.

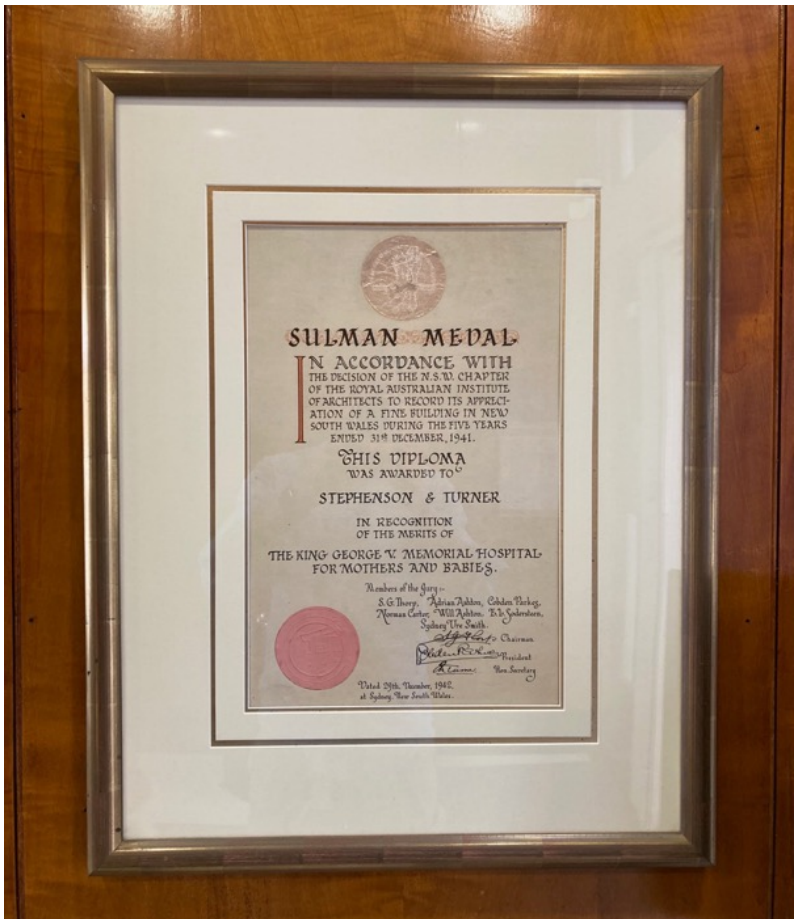


Figure 9 John Sulman Medal

The foyer space within the Admin Building contains most of its original structure including the original marble flooring, ornate timber architraves, dado, corbels, pressed metal ceiling and High Victorian tiles. There are 14 stained glass windows depicting amongst them Queen Victoria, Caritas (Charity), the Royal Coat of Arms and names of various ships and sailors serving at the Australian Naval Station in 1885. Just beyond the doorway where the 1882 building merges with the newer buildings sits modern floor to ceiling glass etchings of original RPA Nightingale Wards and nursing staff images (see Figure 10). Along the southern corridor sits the RPA Main Boardroom. This boardroom contains heritage styled tables and chairs, heritage green carpet, original timber wall panelling and associated room hardware. The walls display framed heritage images and a large 1941 painted Archibald entrant portrait of Sir Herbert Schlink by Fred Leist. Schlink was a surgeon and long serving RPA Chairman of the Board of Directors, and significant influencer in the expansion and development of the Hospital.

Figure 10 Glass Etching (source: Author)

The furniture choices and arrangement of the boardroom is intentional and preserved with purpose. Both the boardroom and main foyer area are preserved with minimal modern technological interruption or intervention. They provide a direct connection to the myths and sagas connected to the 141 year old space and provide a constant reminder of the surrounding heritage listed building. Together they offer an immersive experience suggestive of an organisation that has endured across space and time, and that has gained a wealth of experience, knowledge, and expertise. They are also preserved to provoke an emotional response and connection to the organisation. The spaces present an image that underpins the organisational identity, that aims to influence individual and wider organisational culture and behaviour and helps shape stakeholder individual and collective memory.

Looking further across the campus will find several departments showcasing heritage artworks, imagery or small collections highlighting their individual histories and development. The Cardiothoracic, Anaesthetics, Radiology, Women's, and Babies unit and the VMO (Visiting Medical Officer) lounge located in the 1882 built Nurses Home, today the Kerry Packer Education Centre, display large portraits of doctors significant to the development of those departments. The Radiology Department hallways and waiting room display a further 12 framed RPA Radiology images illustrating the history and progression of that department, and in the waiting-room sits a cabinet showcasing historic radiology equipment. The Anaesthetics department corridor holds a small display cabinet housing objects relevant to that department, and the SLHD Communications team

has a cabinet displaying audio visual camera equipment used by the department over the last 50 years. Each of these displays showcases technology and departmental iterations which demonstrate a strong connection to the departmental history, a sense of pride, and by extension, make a statement. That statement is one of longevity, knowledge, and confidence.

On level 11 of KGV sits the SLHD and RPA Executive Units. The floor is carpeted in heritage green, with numerous heritage desks, side tables, chairs, hat stands, art works and heritage photographic images hung along the corridors and offices (see Figure 11 and Figure 12). The original ship clock from the HMS *Galatea* is wall mounted in office 13-11-24, and the district executive boardroom contains the original boardroom table and chairs along with side tables and other memorabilia.

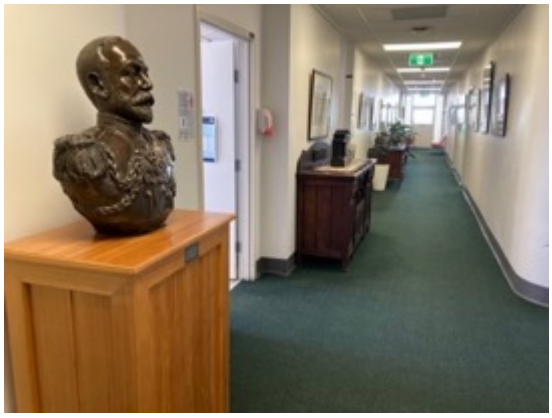


Figure 11 KGV L11 Hallway (source: Author)

Figure 12 KGV L11 Boardroom (source: Author)

Statues, sculptures, and reliefs are purposely positioned across the Hospital grounds. To the front of the KGV building sits a large granite sculpture of King George V (1944). This sculpture divides the only pedestrian pathway into the building (see Figure 13). Two Hawksbury sandstone statues (1946) titled *Maternity* (see Figure 14) in the north wing garden and *The Surgeon* in the south wing garden prominently commemorate birth and care. Each of these statues underwent a significant public unveiling with formal ceremonies celebrating not only their artistic merit but communicating their intent and purpose. At the time of unveiling Dr Herbert Schlink (Royal Prince Alfred Hospital 1944) was noted as saying;

> 'The artist creates for us a symbol which stimulates our ideas and takes us beyond the practical considerations of every day. It is not enough to live and work; some moments must be given over to spiritual contemplation if we are to live a full and complete life'.

Figure 13 King George V statue (source: Author)

Figure 14 Maternity statue (source: Author)

Two large two metre high *Mother and Baby* reliefs adorn the north and south wing eastern faces, and two one metre high Della Robbia styled *Bambini* reliefs sit directly above these reliefs on the 11th floor (see Figure 15 and Figure 16).

Figure 15 Mother and Baby relief (source: author)

Figure 16 Bambini relief (source: author)

A bronze life-sized statue of *Imhotep* (1936) is positioned prominently in the circle garden apposite Gloucester House (see Figure 17). Unveiled by Lady Margaret Wakehurst with 500 people in attendance,

‘it was thought the statue would be a source of inspiration to RPA medical and nursing staff, and would give comfort and hope to in-coming patients as they pass by, that in Gloucester House they will receive the benefit of the accumulated medical and surgical knowledge of over 4,700 years’ (Royal Prince Alfred Hospital 1938).

Figure 17 Imhotep statue (source: author)

Further reminders of the British Royal family exist in two life sized beaten copper statues of Prince Albert and Queen Victoria atop the pediments of the Albert Block and Queen Victoria Block Pavilions. Inside the Mother and Babies Unit entrance sits a marble statue of a mother embracing her baby titled *Maternal Affection* (1951), relocated from its earlier position inside the foyer of the original KGV maternity hospital (see Figure 18).

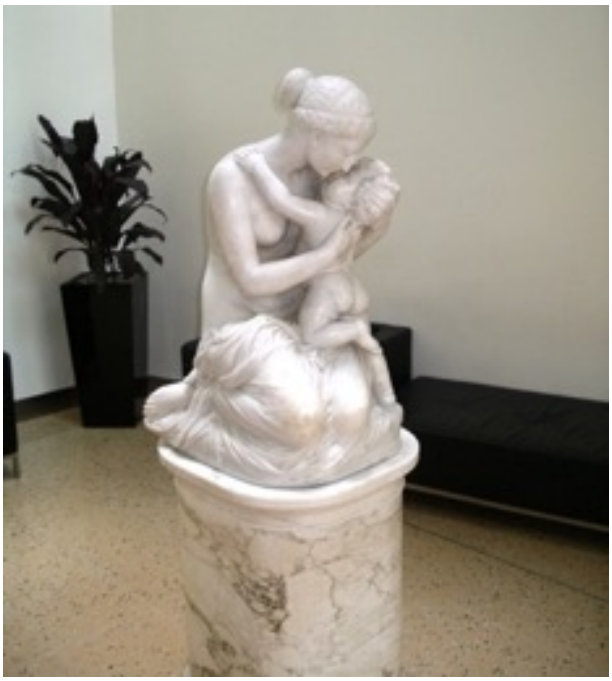


Figure 18 Mother and Baby statue (source: Author)

A further significant architectural heritage feature at the Hospital adorns the entrance to the Pathology Building (1880). A cherub carved in sandstone with Latin script that reads 'In coelo quies est' – 'in heaven, there is rest'. This building and the RPA Chapel will be demolished as a part of the 750 million dollar hospital redevelopment in 2024. The cherub, corbels, stained glass windows and various other building features are to be removed and reintegrated into the new construction or landscape, with the bricks reused for pathway construction (T Anderson 2023, personal communication, 23 June).

The history and heritage of departments is actively celebrated across the campus through other means such as historic graphic wall timelines. Upon opening the new Women's and Babies Unit in 2002 in the newly built Clinical Services building, an historic wall timeline was installed celebrating and commemorating the history of the John Spence Nursery and midwifery services, previously located in the KGV building. In 2017, the Renal Unit relocated to a newly constructed facility in which an historic timeline graphic was installed in the waiting area celebrating the history, staff and milestones of the unit, including the departmental highlight of the 3000th kidney transplant (see Appendix F). In 2019, RPA launched a virtual hospital – **rpa**virtual – a NSW first. A wall graphic was installed documenting and celebrating the history of home care, telehealth, and virtual healthcare in connection with RPA. Such installations again commemorate the history of those units and celebrate

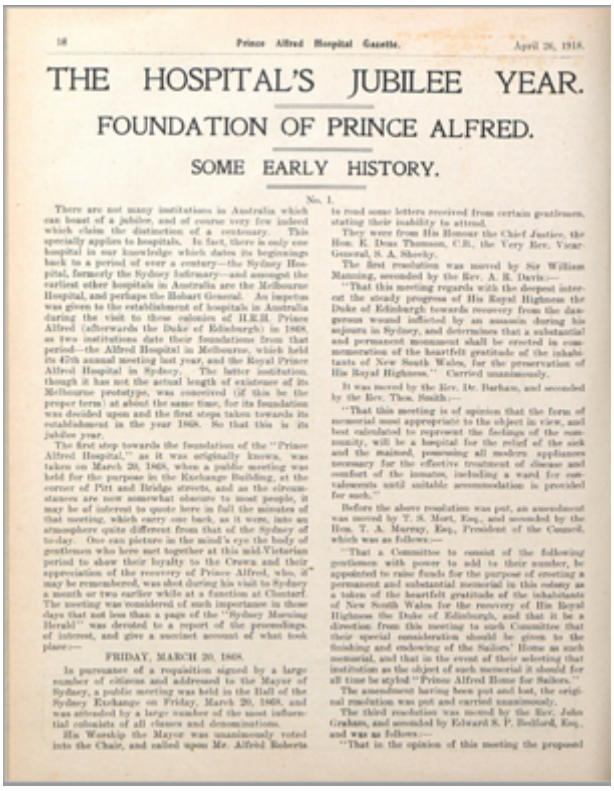
the journey and development of those services. They also provide performative roles instilling confidence in patients and visitors, and education and pride in staff.

On level eight of the KGV building sits the RPA Museum. An historic wall timeline highlighting the attempted assassination of Prince Alfred and the story behind the founding of the Hospital, along with an explanation around the development of the museum, have been installed along the northern hallway (see Figure 19). Various artifacts including transoms and copper beaten ward naming plaques from demolished buildings are wall mounted in the corridor, and a 1950's *Both Iron Lung* sits near the stairwell exit. The museum, 90 years old in 2023, maintains a collection of over 6000 objects and collects and preserves hospital cultural heritage and organisational history showcasing RPA's people, clinical services, and events. The collection includes artworks, images, medical and administration documents, workforce documents, medical equipment, medical education materials and equipment, and nursing memorabilia. Two display rooms are situated inside the original 1941 steel domed educational operating theatres.

Figure 19 RPA Museum wall timeline (source: Author)

The museum also holds digital and hard copies of RPA annual reports, first published in 1883 and the RPA Gazette, first published in 1902. The gazette was published quarterly until 1988, and the annual report until 1987 when it was folded into a district wide report and then into the NSW Health Annual Report in 2008. In 2001 the local health district Year in Review was launched to highlight and showcase the past year across the district services and facilities. Each of these publications refers to or utilises some historic component of RPA to celebrate milestones, changes of practice, expansion

of services or the long association with the University of Sydney Medical School (see Figures 20, 21, 22, 23). RPA built heritage features prominently, as does celebrating new achievements and organisational or industry firsts through remembering and highlighting past acts to demonstrate the developments and advancements of a particular department or clinical service.



18 Prince Alfred Hospital Gazette. April 26, 1918.

THE HOSPITAL'S JUBILEE YEAR.

FOUNDATION OF PRINCE ALFRED.

SOME EARLY HISTORY.

No. 1.

There are not many institutions in Australia which can boast of a jubilee, and of course very few indeed which claim the distinction of a centenary. This specially applies to hospitals. In fact, there is only one hospital in our knowledge which dates its beginnings back to a period of over a century—the Sydney Hospital, formerly the Sydney Infirmary—and amongst the earliest other hospitals in Australia are the Melbourne Hospital, and perhaps the Hobart General. An impetus was given to the establishment of hospitals in Australia during the visit to those colonies of H.R.H. Prince Alfred (afterwards the Duke of Edinburgh) in 1868, as two institutions date their foundations from that period—the Alfred Hospital in Melbourne, which held its 47th annual meeting last year, and the Royal Prince Alfred Hospital in Sydney. The latter institution, though it has not the actual length of existence of its Melbourne prototype, was conceived (if this be the proper term) at about the same time, for its foundation was decided upon and the first steps taken towards its establishment in the year 1868. So that this is its jubilee year.

The first step towards the foundation of the "Prince Alfred Hospital," as it was originally known, was taken on March 20, 1868, when a public meeting was held for the purpose in the Exchange Building, at the corner of Pitt and Bridge streets, and as the circumstances are now somewhat obscure to most people, it may be of interest to quote here in full the minutes of that meeting, which carry one back, as it were, into an atmosphere quite different from that of the Sydney of to-day. One can picture in the mind's eye the body of gentlemen who here met together at this mid-Victorian period to show their loyalty to the Crown and their appreciation of the recovery of Prince Alfred, who, it may be remembered, was shot during his visit to Sydney a month or two earlier while at a function at Clontarf. The meeting was considered of such importance in those days that not less than a page of the "Sydney Morning Herald" was devoted to a report of the proceedings, of interest, and give a succinct account of what took place:—

FRIDAY, MARCH 20, 1868.

In pursuance of a requisition signed by a large number of citizens and addressed to the Mayor of Sydney, a public meeting was held in the Hall of the Sydney Exchange on Friday, March 20, 1868, and was attended by a large number of the most influential colonists of all classes and denominations.

His Worship the Mayor was unanimously voted into the Chair, and called upon Mr. Alfred Roberts to read some letters received from certain gentlemen, stating their inability to attend.

They were from His Honour the Chief Justice, the Hon. E. Deas Thomson, C.B., the Very Rev. Vicar-General, S. A. Sherdy.

The first resolution was moved by Sir William Manning, seconded by the Rev. A. R. Davis:—

"That this meeting regards with the deepest interest the steady progress of His Royal Highness the Duke of Edinburgh towards recovery from the dangerous wound inflicted by an assassin during his sojourn in Sydney, and determines that a substantial and permanent monument shall be erected in commemoration of the heartfelt gratitude of the inhabitants of New South Wales, for the preservation of His Royal Highness." Carried unanimously.

It was moved by the Rev. Dr. Barham, and seconded by the Rev. Thos. Smith:—

"That this meeting is of opinion that the form of memorial most appropriate to the object in view, and best calculated to represent the feelings of the community, will be a hospital for the relief of the sick and the maimed, possessing all modern appliances necessary for the effective treatment of disease and comfort of the inmates, including a ward for convalescents until suitable accommodation is provided for such."

Before the above resolution was put, an amendment was moved by T. S. Mort, Esq., and seconded by the Hon. T. A. Murray, Esq., President of the Council, which was as follows:—

"That a Committee to consist of the following gentlemen with power to add to their number, be appointed to raise funds for the purpose of erecting a permanent and substantial memorial in this colony as a token of the heartfelt gratitude of the inhabitants of New South Wales for the recovery of His Royal Highness the Duke of Edinburgh, and that it be a direction from this meeting to such Committee that their special consideration should be given to the finishing and endowing of the Sailors' Home as such memorial, and that in the event of their selecting that institution as the object of such memorial it should for all time be styled "Prince Alfred Home for Sailors."

The amendment having been put and lost, the original resolution was put and carried unanimously.

The third resolution was moved by the Rev. John Graham, and seconded by Edward S. P. Bedford, Esq., and was as follows:—

"That in the opinion of this meeting the proposed

Figure 20 Royal Prince Alfred Hospital Gazette, April 1918, page 18 (Source: RPA Museum)

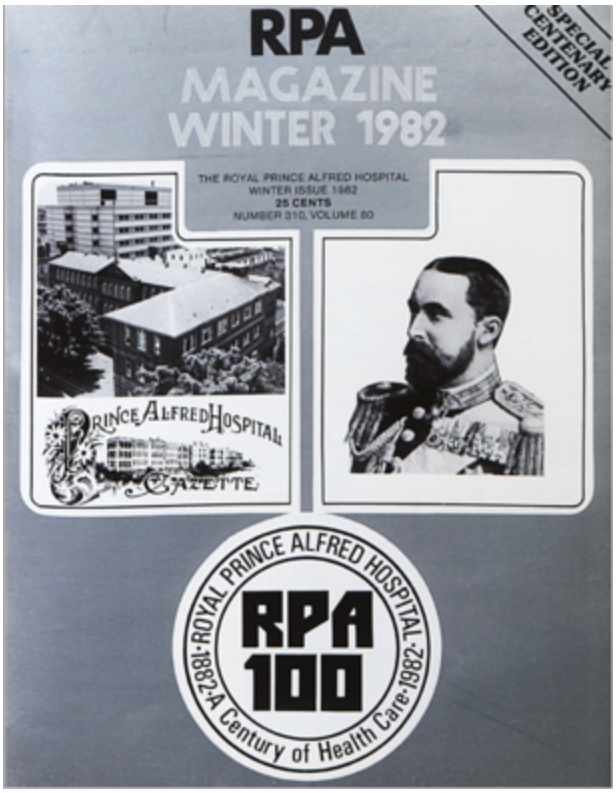


Figure 21 Royal Prince Alfred Hospital Gazette, Winter 1982, front cover (Source: RPA Museum)

Figure 22 Sydney Local Health District Year in Review 2017-2018, page 26 (Source: RPA Museum)

Figure 23 Sydney Local Health District Year in Review 2018-2019, page 26 (Source: RPA Museum)

Further examples of the use of heritage as demonstrations of the Hospital's connection to foundation values are evident in events and celebrations across the organisation. Such events include the 1982 Centenary Celebrations, the 125 Anniversary Celebration, and the 140 Anniversary Celebration. In 2022 a week-long celebration occurred to celebrate the 140th birthday of RPA. Heritage in the museum and from across the campus was used to celebrate and commemorate the long and complex journey and history of the Hospital (see Sydney Connect 2022). New material artifacts such as the RPA 140 Years picture book with extended captions was published, and glass drink coasters and gold pins branded with the original RPA emblem crest were developed and given to staff. A staff sausage sizzle and staff picnic took place in the 1892 Nurses' Home fountain courtyard, and guided walking heritage tours were organised (Sydney Local Health District 2022). The week culminated in a Gala Dinner with numerous speeches and further commemorative artifacts given to attendees to celebrate the milestone and occasion. Such events and celebrations serve to 'recollect the past as active, constructive processes' (Schwartz 1982, p. 374), and 'serve as focal points in the drama of re-enacted…participation' (Halbwachs 1992, p. 24). They also serve as management control mechanisms designed to foster pride and a sense of cultural and organisational unity, while providing distance from dissonance and subcultural divergence. Further, they help 'facilitate intergenerational communication and connection' (Smith 2021, p. 305) and strengthen the

organisational collective memory. This in turn assists in the positive development and support of organisational stakeholder physical and mental wellbeing.

Heritage material was also actively collected, preserved, and developed by the organisation during the COVID-19 pandemic. Kosciejew (2022, p. 20) argues that 'remembering the coronavirus pandemic represents an obligation to the present and the future'. Further, that it presented an opportunity to actively decide what aspects of material culture should be collected now for future representations of the event (Spennemann 2022), which will 'directly shape future remembrance, reference and study' (Kosciejew 2022, p. 30). Heritage associated with the pandemic, or 'emergent heritage' was immediately identified by the organisation and measures were put in place to collect and preserve the response as it occurred, rather than be reliant on what Mubarek (2021) calls retroactive or passive collecting. The pandemic, as noted by Jones et al. (2021, p. 547) offered 'an opportunity to preserve a rich and diverse historical record—one intended to honour all experiences and voices and in recognition of the ongoing structural inequalities that must not be lost to future histories'.

The Sydney artist Simon Fieldhouse was approached by the district communications team as part of their documentation of the COVID-19 response. Fieldhouse works in watercolour and pen to transpose, reinterpret and document important built heritage and society's wider collective moments. A partnership was formed with the artist to capture and interpret the COVID-19 story in the SLHD. This author, who had been seconded to the newly formed Special Health Accommodation unit as Quarantine Hotel Site Manager was requested in January 2021 to photo-document daily activity at the hotels. Trained and accredited in infection control, and having full access to the facility, appropriately considered moments were photographed, collected, and collated and archived for posterity. Simon Fieldhouse then reinterpreted many of these images in watercolour. In an interview with the communication team, Fieldhouse described his role as 'wartime artist' (C McKay 2021, personal communication, 11 June). His artworks will feature in numerous future exhibitions and represent an important heritage archival process and material collection of organisational artifacts for future generations.

Conclusion

This chapter has demonstrated the numerous ways in which heritage has been intentionally and purposefully used to date. Heritage has been consistently embraced and actively used by the Hospital executive management and district communications teams to underpin significant events

including hospital birthdays and redevelopments, and by departments and clinical streams to celebrate and commemorate staff retirements, unit relocations and refurbishments, and clinical milestones.

Royal Prince Alfred Hospital material heritage is both as numerous and varied as are the complexities surrounding its management within a healthcare setting such as a large public hospital. These complexities, often in direct opposition to the provision of effective healthcare, emerged as a result of the struggle between an organisation striving to be a modern leader and innovator, and one actively attached to its history and heritage.

Several drivers led to the recognition and preservation of heritage at RPA. Individual organisational member pride in the operations, development and history of the Hospital saw both small and large heritage collections develop. The organisational executive bodies supported the preservation of heritage closely aligned to the foundational stories and values set in 1876 as evident in the preservation of early archival material.

The next chapter, Chapter 3, will explore the literature surrounding conceptions of organisational cultural heritage and will discuss and link organisations, heritage, culture and identity, and value perceptions of heritage including economic and non-economic valuation methods.

Chapter Three: Cultural Heritage and Organisations in Context

Introduction

The review of literature in this chapter discusses the key terms and concepts used in the thesis, and situates them within Heritage Studies and Organisational Management Studies, the key disciplines from which the thesis draws upon. The interdisciplinary nature of this research and thesis requires a multifaceted approach exploring on one hand, the nature of cultural heritage, and conceptual frameworks surrounding heritage perception and value, and on the other, the various components that comprise a large government organisation and public hospital such as RPA. The purpose of this literature review is to provide the reader with an understanding of the field under investigation, and a conceptual framework that will underpin researcher theoretical sensitivity during data collection and analysis, as required by grounded theory research and discussed in Chapter 4.

This chapter identifies and argues that material organisational cultural heritage is largely an underexplored or ignored organisational material artifact and symbol that is central to constructions of organisational culture and identity. Further that perceptions of organisational heritage offer complex insights that can be leveraged by hospital leadership for use as an organisational instrument.

The chapter begins with a short discussion exploring the nature of the modern hospital, and reviews conceptions of organisational culture and identity to highlight the numerous complexities that exist within large complex anchor institutions like RPA Hospital. Cultural heritage frameworks are then explored discussing conceptions of heritage and the surrounding dissonant discourse on socio-cultural and economic heritage values. An exploration into materiality and artifacts within organisations follows this, identifying the role and value of material artifacts, and their use as symbols, actors, and control mechanisms. The chapter closes by examining corporate heritage and corporate museums and provides insight surrounding their meaning and value to corporate organisations.

Hospitals as Heritage Organisations

Hospitals are complex microcosms of society containing cultural, social and medical histories ‘charged with paradoxes and contradictions’ (Wagenaar 2020, p. 37), and are the most complex form of human organisation ever managed (Drucker 2012). As a result there is a ‘sociological

tradition of studying hospitals as sites for professional socialisation, the enactment of medical hierarchies' and to explore the external influences that shape hospital-based care (Franz et al. 2019, p. 1). An investigation into the literature suggests hospitals have never been studied as heritage organisations or as organisations actively preserving and using heritage to engage organisational members. It is therefore essential to explore the nature of hospitals to further discussions of cultural heritage as situated within a specific framework of broader society and within a unique type of organisation across time.

Hospitals have evolved from places for 'the sick poor' (Armstrong 1965, p. 75) to become organisations that are institutions defined and designed by a scientific approach to architecture, innovation, and medicine (Jenkins et al. 2022; Wagenaar 2020). As illustrated in Chapter 2, they are less 'facts' or 'things' but are complex social constructions and a form of social life that Weick (1985) describes as negotiated, fluid and emergent. As such they are complex adaptive non-static systems that are constantly and permanently modified in that they form, reform and deform, adapt, shape and change 'according to experiences, stimulation, communication, information and the environment' (Fajardo-Ortiz et al. 2015, p. 83).

Modern hospitals constitute unique systems and subsystems that 'house a multitude of functions, purposes and people' (Dias 2009, p. 146). They exist at the centre of a healthcare industry that experiences rapid change as a result of medical advances through biomedical and genetic research, and developments in digital and information technology that together produce rapid changes in clinical care' (Borkowski & Meese 2020, p. 4). The unique environments of hospitals are further 'shaped by geographic location, architectural design, size, internal organisation, and financial base' (Risse 1999, p. 6). They contain a cross section of professional and non-professional services ranging from clinical to administrative, and from the arts and heritage to education. Large public hospitals like the one under investigation in this thesis – RPA – are at once treatment clinics, centres of research and innovation, teaching facilities, industrial complexes, hotels, and anchor institutions. Anchor institutions are stable organisations with a long term community presence that provide 'significant economic contributions as employers and purchases of local services' (Cronin et al. 2022, p. 2). They undertake significant and ongoing investment into infrastructure with 'a mission oriented towards community engagement and social service' (Harris & Holley 2016, p. 8). They can 'mark central points in people lives' often reflecting 'the needs and values of the communities in and around them' (World Health Organization 2023).

Hospitals like RPA, with long histories and a strong community presence are at once producers of heritage, caretakers of heritage and users of heritage. The ways in which heritage has been investigated within a healthcare organisation are extremely limited and generally peripheral in scope. Research has focussed on the complexities surrounding heritage infrastructure management and maintenance (see Gomes et al. 2021), the issues arising through the provision of clinical services from within heritage built infrastructure (see Lanklord et al. 2003; Tyson et al. 2002), one study investigating the use of heritage to impact patient health and wellbeing (see Ander et al. 2013; Paddon et al. 2014) and another using heritage to teach communication skills to medical students (Noble 2011).

There are extensive explorations into hospitals from other research disciplines that exclude heritage as a centre of focus. Research centring on art in health has proven diverse with Lankston et al. (2010, p. 490) noting art has been demonstrated to 'have positive effects on health outcomes, including shorter length of stay in hospital, increased pain tolerance and decreased anxiety' (see Adamaitis 2020; Diette et al. 2003; Hathorn & Nanda 2008; Rollins 2021; Staricoff et al. 2003; Tse et al. 2002). There are opportunities to explore hospital heritage environments and their impacts on patient stays and patient outcomes. There is also an abundance of research into hospitals as organisations and institutions that again exclude heritage as a point of discussion. Research within the Organisational Management Studies literature explores hospitals as complex systems from a strategic management and strategy implementation perspective (see Ginter et al. 2018; Meyer Junior et al. 2012; Meyer et al. 2016; Schneller et al. 2023), as high reliability organisations (Bagnara et al. 2010; Polonsky 2019; Tolk et al. 2015), as businesses (see Foglia et al. 2022; Giancotti et al. 2017; Kruse & Jeurissen 2020; Rosenthal 2018) and as total institutions (Jenkins et al. 2022). Research surrounding hospital management and structure typically focus on clinical care and patient outcomes (see Brindle & Gawande 2020; Griffiths et al. 2009; Zingg et al. 2015) governance (see Cardinaels & Soderstrom 2013; De Regge & Eeckloo 2020), and hospital socialisation processes (see Gittell 2009; Strauss et al. 1997; Zarshenas et al. 2014). The above examples are but a few selected to demonstrate the diverse types of investigations framed within hospitals. Hospitals explicitly researched as heritage organisations is a gap yet to be explored. The presence of heritage within a hospital has the capacity to influence the organisational culture and identity at multiple levels and in a myriad of ways. This will be explored in Chapter 3 which examines the history and heritage of RPA Hospital.

Organisational Identity

Organisational identity has been researched extensively in the organisational theory literature (see Albert & Whetten 1985; Brown et al. 2006; Gioia et al. 2000; Hatch & Schultz 1997; Pratt et al. 2016) resulting in diverse and complex discussions. The identity frame offers 'creative ways to understand a range of organisational settings and phenomena while bridging the levels from micro to macro' (Alvesson et al. 2008, p. 7). Ernst and Jensen Schleiter (2021) suggest research areas focussed on how identity emerges or is constructed (see Alvesson & Robertson 2016; Brown 2019; Watson 2016) and on the capacity for agency in identity generation (see Albert & Whetten 1985; Alvesson et al. 2008; Alvesson & Willmott 2002; Doolin 2002). Views further diverge in the field with some scholarship emphasising 'external factors contending that organisational identity is determined by institutional forces, whilst others focus on internal factors and describe organisational identity as socially constructed by organisational members' (Min et al. 2020, p. 847). Identity research has thus far provided insight into 'questions of motivation, individual and group behaviour, communication patterns, leadership and managerial work, organisational change, corporate image, inter-organisational interaction, dynamics of control and resistance, and relations of gender and race-ethnicity' (Alvesson et al. 2008, p. 7). Brown (2019) notes however there are still several areas yet to be adequately explored or understood. An exploration of the literature by this author finds hospital heritage has not been explored as an identity referent.

The field of hospital identity has been comprehensively researched to explore general staff and departmental engagement, interaction, division, and organisational change (see Kreindler et al. 2012; LaTendresse 2000; Pratt & Rafaeli 1997; Pratt et al. 2006; Shnapper-Cohen et al. 2023). These studies are concentrated at the micro level of analysis exploring issues that emerge from hospital professional identification and the development of sub-cultures. Ernst & Jensen Schleiter (2021, p. 15) propose that 'in order to understand organisational identity, we must take the nature of the organisation and its historical context into account'. Government organisations like hospitals are accountable to a wide collection of stakeholders, and consequently are faced with institutional pressures and relations of power complexities and ambiguities and as a result are sites of complex identity struggles (Ernst & Jensen Schleiter 2021). As a consequence, government organisations tend to struggle more with constructions of identity than do those in corporative private sectors (Dutton & Dukerich 1991). Comparative literature connecting heritage and organisational identity at other anchor institutions like universities centres around identity transition, visual identity, and reputation impact to the exclusion of heritage (see Alessandri et al. 2006; MacDonald 2013; Steiner et al. 2013). This unique gap offers important insight and a novel perspective into hospital processes, outcomes

and change within a complex organisational environment. This research will build on this notion and expand the field of organisational identity to explore the interplay of hospital heritage and social identity, and the influence cultural heritage exerts more widely on hospital organisational identity.

Organisational identity can best be considered a shared answer to 'who we are' as opposed to 'who am I' (Mujib 2017). In its simplest form, identity is how we make sense of ourselves and emerges out of the intersection of interaction, negotiation and a shared processes of sensemaking (Weick 1995). Additional influence and shape occur through our engagement with marketplace, religion, language, culture, race, gender, sexuality. Organisational identity is then 'grounded in local meanings and organisational symbols, and thus is also embedded in organisational culture (Hatch & Schultz 1997, p. 358). This sense of identity connects and bonds these diverse experiences reducing possible feelings of fragmentation (Alvesson & Willmott 2002). Together, they interact to build and reflect larger social and cultural identities.

Albert and Whetten (1985) formulated an early tripartite conceptualisation of organisational identity as being central, enduring and distinctive (CED hereafter). The first and central component constitutes the most used characterisation of organisational identity. It entails how organisational members perceive and understand who we are, what we stand for and what we want to be as an organisation (Albert & Whetten 1985). Identity is a root construct in organisational phenomena and consequently is a central and core phenomenon of organising. The second component is that an organisation's identity must be distinctive. It is what separates one organisation in the same sector from another. The third is that it must be enduring. This third construct is a contested notion as some scholars argue identity is fluid and changing, and possesses a 'malleable property, readily and routinely altered to reflect shifting environmental circumstances' (Whetten 2006, p. 220). Under this conceptualisation, identity does not need to endure, and under some circumstances, cannot endure. Contestation occurs within this conception of organisational identity as it is arguable that those characteristics that persist as being malleable are in fact image-related and manufactured elements of organisations. They do not constitute organisational identity and are instead related to organisational image.

Organisational identity referents such as the central, enduring and distinctive dimensions proposed by Albert and Whetten (1985) are the institutionalised reminders of significant organising (Baron 2004). According to Brickson and Brewer (2001), identity-based directives are obligatory, not advisory. This obligation ensures that organisations avoid becoming indistinguishable and

unrecognisable (Whetten 2006). Heritage and the use of history are key components in distinguishing one organisation from another. In the case of RPA Hospital, the organisational history and heritage is unique and distinct to that of other health organisations and hospitals in Australia, due to a unique foundational story and subsequent development as a public hospital (see Chapter 2). As such, identity constitutes the core of an organisation in grounding it with a unique history, with particular values, through mission alignment, and with common goals that function as a filter to screen and frame future action. As a component of that identity, heritage it is a tool for collective memory and can serve as self-conscious and critical tools for 'negotiating and defining the social and moral values that underpin and define' cultural identities (Smith & Campbell 2011, p. 85). Further, heritage can aid in the development and assertion of self-worth and self-respect at both individual and group levels (Smith & Campbell 2011) 'making, negotiating and transmitting memories and social values for and in terms of present needs and aspirations' (Smith & Campbell 2011, p. 101). These aspirations constitutive smaller components that help drive individual and wider organisational actions.

Organisational identity contributes to coherent, consistent organisational action, and is a cornerstone of and springboard for operational strategy and organisational purpose. The implicit and explicit power of organisational identity as a managerial control mechanism assists in the creation of a coherent organisational identity (Askay 2017). Organisational pursuit and maintenance of organisational identity may guide organisational action and behaviour in functioning as a control measure to counteract or limit response to contingencies with 'limitless plasticity' (Alvesson & Willmott 2002, p. 625). For example, management recruit new staff, reshuffle existing staff, reshape departments, and even locate organisations based on the maintenance of identity or in response to changing external contingencies that necessitate change in order to stay the same.

Whetten (2006) suggests there are two bases for determining organisational action: comparative and historical. The comparative frame can be equated to an organisation's drive for legitimacy or accountability. Organisational actions are derived from the need to remain consistent and thus meet stakeholder expectations, i.e., 'we will do Z, because Z is expected of us'. The historical perspective views organisational actions as derived from the intersection of identity, integrity, and normative conceptions of organisational character. For example, 'we must do Z, because Z is consistent with our historical pathway, and known strategy'. Consequently, much organisational identity is path-dependent, and reliant on retrospective sensemaking of the CED dimensions.

Watkiss and Glynn (2016, p. 312) suggest organisational identity is in part constructed through 'processes of categorisation, symbolisation and repertoires of performance'. Hospitals are intergroup contexts with staff members identifying with and classifying themselves according to their various 'professions (e.g., medicine, nursing), different specialties (e.g., emergency medicine, gastroenterology), and different levels (e.g., junior and senior doctors) acting and interacting together' (Hewett et al. 2015, p. 72). Within this, group memberships are then further affected by the hierarchical role-bound departmentally divided nature of the working environment (Riskin et al. 2015). Hospitals have long developed, firmly embedded social hierarchies and identity-based groups. Such tensions have led to RPA as having a multi-dimensional identity. Hospital members classify themselves in several ways according to their professional groups and departmental services. Shnapper-Cohen et al. (2023, p. 13975) recently found 'that departmental identity is the most prominent social identity associated with hospital staff'.

RPA is no different in that staff are either clinical or administrative. If they are clinical then they are doctors, nurses, or allied health staff. If they are doctors, they are clinical stream, diverse specialities and departmentally connected. If they are nurses, they are departmentally connected, full time, casual pool, or agency staff. Within these groups staff are then further separated as junior verses senior (Hewett et al. 2015). Administrative staff can be categorised as being connected to corporate services or engineering and capital works. Corporate services is further then delineated by environmental service staff, unit business managers, dieticians, food services, transport teams and many more.

Korostelina (2019, p. 85) suggests the 'processes surrounding the use, conservation, and management of heritage that emphasise the historic roots of groups are deeply embedded in the complex relations of identity and power in existing intergroup conflicts'. Values surrounding hospital heritage can be 'based on explicit judgments about the importance of specific events, people, or places' (Korostelina 2019, p. 86), and may as a result diverge. Through a variety of internal organisational voices, narratives 'evolve, compete, overlap, intertwine, distance and often contest each other's hegemonic reach' (Brown et al. 2005). These interactions may as a result lead to an organisation being 'characterised by identity multiplicity' (Brown et al. 2005, p. 312). Some identity theorists argue that multiple organisational identities can enhance organisational flexibility, while others argue that they 'can lead to organisational inaction or vacillation' (Pratt & Foreman 2000, p. 22). Further, that organisational culture, discussed in the next section, is comprised of multiple layers of individual and group identities and beliefs that may present as contradictory value systems

within a single organisation (Morgan & Ogbonna 2008). Multiple identities may also force an organisation to expend unnecessary resources reconciling identity and the resulting intra-organisational conflict (Pratt & Foreman 2000). Pratt and Foreman (2000) posit that by fusing important identities into a single identity, that single identity can then be focussed on, thus allowing for more effective and efficient organisational responses.

Organisational identity is derived from more than 'collective self-definitions of *who we are* but also … from *what we do*' (Watkiss & Glynn 2016, p. 325). The sources and processes of organisational identity are bound by and connected to forms of materiality, and are manifested in artifacts, products and practices. Bechky (2008, p. 100) adds that 'identity is constructed through individual artifact contact', and through a sense of what Knorr Cetina (1997, p. 20) calls 'bondedness and unity … [and] moral sense and states of excitement reaffirming the bondedness'. For an organisation to construct an effective identity it must demonstrate the 'deepest commitments – what it repeatedly commits to be, through time and across circumstances' (Whetten 2006, p. 224). Failure in these commitments will see an organisation risk becoming unpredictable and unknown (Whetten 2006).

CED dimensions also function as organisational referents when members are speaking on behalf of an organisation (Whetten 2006). Whetten (2006) argues that internally these referents often fail to effectively resonate within an organisation as they can appear forced and artificial, and as a consequence offer little value as small decision-making tools. CED referents are, however, indispensable for 'fork-in-the-road choices, especially when a contemplated course of action might be considered out-of-character by a legitimating audience' (Whetten 2006, p. 226). Whetton (2006) notes however that not all institutionalised organisational features should be viewed as identity referents but all identity referents must be viewed as organisational features. Determining the extent to which heritage functions as an identity referent will further understanding surrounding the value of heritage to a complex organisation like RPA. It will also offer insight into the construction and function of the organisational culture.

Organisational Culture

Organisational culture differs from organisational identity in that it represents the collective deeply seated values, beliefs, principles, symbols and practices shared by organisational members (Schein 2017). It is a 'set of shared mental assumptions that influence, shape and guide interpretation and action in organisations by defining appropriate behaviour for various situations' (Ravasi & Schultz 2006, p. 437). These assumptions define the way in which an organisation inwardly and outwardly

functions, how members interact and engage, and how business is conducted (Barney 1986). Scott-Findlay & Golden-Biddle (2005) suggest 'from this perspective organisational culture is a socially constructed phenomenon, expressed in the patterns of behaviours (including physical, cognitive, and affective behaviours)' of its organisational members.

The concept of organisational culture is a widely contested notion due to its ubiquitous nature as it can mean different things to different people depending on the lens applied (Birukou et al. 2013). Davies et al (2000, p. 112) note there are over fifteen different descriptions of culture in the management and organisational theory literature, however two distinct views can be distinguished. One view suggests organisational culture as a variable that an organisation 'has' which 'can be manipulated of changed to achieve better control and to improve organisational effectiveness ' (Scott-Findlay & Golden-Biddle 2005, p. 360). Organisational culture is then both a 'product of human enactment', and a 'product of the environment', that exerts patterns of influence on an organisation (Scott 2003, p. 19). This view conceives culture as something than can be 'isolated, described and manipulated' (Davies et al. 2000, p. 112). Harrison (2000, p. 426) contends that viewing culture as something an organisation 'has' is limiting as this framing seeks to confine culture as an organisational variable that can be taught to new members and used as a strategic tool to 'enhance productivity or competitiveness'. Culture cannot be easily dissected and manipulated as it is not 'bounded or fixed, but instead continually changes as it is a contingent, contradictory, ambiguous, multivalent phenomenon'(Harrison 2000, p. 426). The other view treats culture as a 'metaphor for conceptualising organisation' (Smircich 1983, p. 355) suggesting culture is something an organisation 'is' in that it lacks 'concreteness', and is indistinguishable from the organisation itself. Scott (2003, p. 19) suggests this shifts conceptions of culture from being a distinctive variable, to culture 'as the context for all variables'. Both conceptions of culture however are to varying degrees intersectional and are not so easily separated (Parker & Bradley 2000).

Conceptions of organisational culture are heavily dependent upon research agendas which in turn decide as to whether culture is approached from a cognitive, a symbolic or through a structural and psychodynamic perspective (Smircich 1983). Martin and Frost (1996, p. 360) suggest 'cultural approaches' are drawn from a myriad of 'theoretical viewpoints, borrowing only a subset of the available ideas about culture'. As example, 'stakeholders such as customers, shareholders or environmentalists' may view an organisational culture as 'fragmented and conflict-ridden', managers may view culture as integrated and performance related, while outsiders may see culture as symbolic management strategies intended to influence outcomes (Martin & Frost 1996, p. 360).

At least some attributes of culture are agreed upon in the literature in that cultures can be integrated, differentiated or fragmented, and that each of these views can be applied to the same organisation (Martin 1992). Davies et al. (2000, p. 115) describes these as:

1. **Integrated:** Integrated cultures occur when there is wide consensus on the basic beliefs and appropriateness of behaviours within the organisation.
2. **Differentiated:** Differentiated cultures occur when multiple groups within an organisation possess diverse and often incompatible views and norms. The NHS has long existed as a collection of loosely coupled differentiated cultures (medical, nursing, professions allied to medicine, administrative and, more recently, managerial groups).
3. **Fragmented:** Fragmented cultures may diverge and fragment to such an extent that cross-organisational consensus and norms are absent. Even within specific groups, differences may be more marked than commonality, and agreements that are seen may be only fleeting and tied to specific issues. Thus, the organisation is characterised by shifting alliances and allegiances, considerable uncertainty and ambiguity, and unpredictability.

Culture is also a process and provides a means for the transmission of meaning to organisational members (Schein 2017), serving two significant internal functions: integration and coordination, which together contribute to or prevent organisational success (Furnham & Gunter 2015). The notion of learned and transmitted are central to understanding organisational culture as culture embodies and encapsulates past experience (Walsh & Ungson 1991). Through the transmission of culture, members can be influenced to feel positive towards an organisation, which in turn assists in the development of commitment and loyalty, or negative thereby creating dissention and conflict. Further, it can contribute to driving members to strive harder thus creating 'unusual levels of motivation' and collaboration (Fullan 2011, p. 85; Kotter & Heskett 2008).

Like other organisations, hospitals must seek to understand 'the implicit beliefs, values and assumptions existing within hospital organisations that motivate and shape the behaviour of participating members' (Klingle et al. 1995, p. 167). Organisational members can draw upon culture to 'understand how things operate within the organisation' (Scott-Findlay & Golden-Biddle 2005, p. 360), and heritage offers an additional lens through which culture can be understood. The impact of heritage on hospital culture is not understood in the organisational theory, heritage studies or hospital management literature. Literature surrounding hospital culture is focussed on hierarchies

and leadership (Bate 2000; Tsai 2011), patient quality improvement (Davies et al. 2000; Kaplan et al. 2010; Parker et al. 1999), patient outcomes (Braithwaite et al. 2017), influence on clinical practice (Borg et al. 2015; Braun et al. 2020; van Buijtene & Foster 2019) and performance and change management (Jacobs et al. 2013; Jones & Redman 2000; Mallak et al. 2003). There is no analysis of the interaction between hospital heritage and culture, or how it impacts organisational member values, beliefs, and practices. There is an interplay between organisational culture and heritage and that requires investigation and analysis.

Under Schein's (2017) seminal analysis of organisational culture, culture manifests itself via three levels described as observable artifacts, values and basic underlying assumptions (see Figure 24). These dimensions 'differ in terms of their visibility and their resistance to change' (Kotter & Heskett 2008, p. 4). They are however linked, iterative and relational in that 'artifacts are manifestations of values, while values are manifestations of assumptions' (Scott-Findlay & Golden-Biddle 2005, p. 360). The theoretical framework formulated by Schein will be used to better understand the meaning and value of heritage to the organisation that is RPA Hospital in Chapter 6.

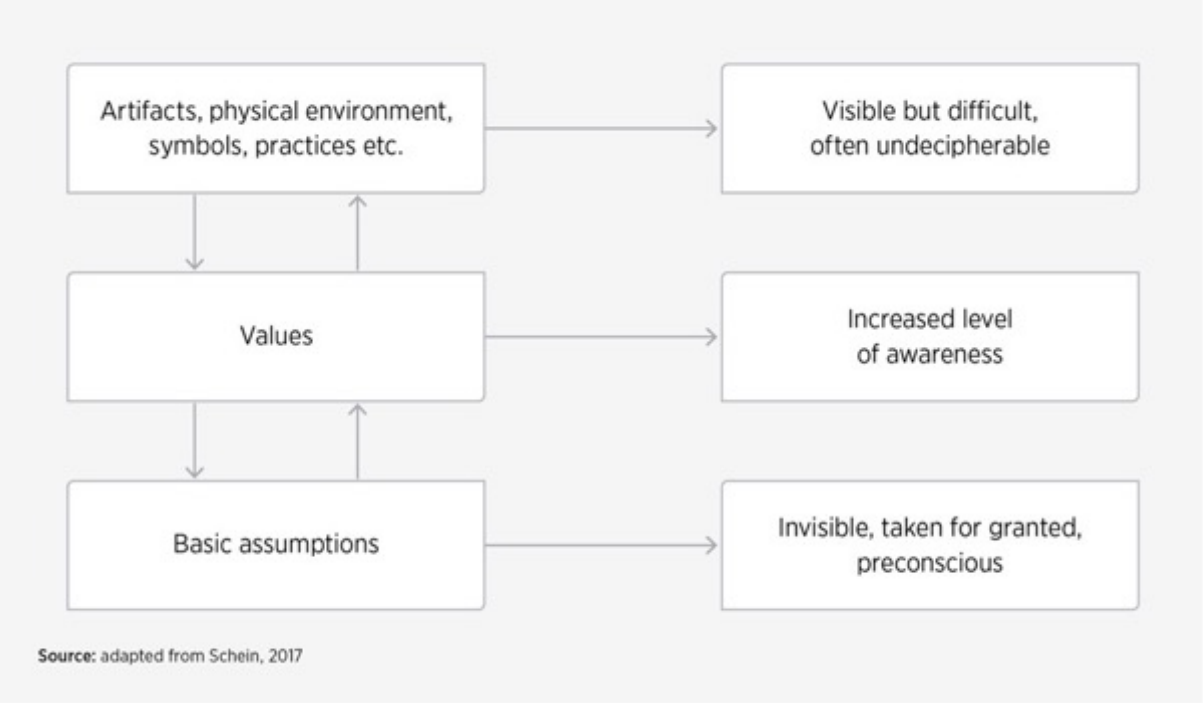


Figure 24 Organisational Culture (source: Author, adapted from Schein, 2017)

The first and most superficial layer, the observable visible artifacts constitutes both material and non-material elements including the physical environment, myths, observable rituals, and practices, and easily articulated values. Cultural practices and rituals are significant to an organisation as it is

the participants in a culture 'who give meaning to people, objects and events' (Hall 2003, p. 3). Hall (2003, p. 3) suggests:

> Things 'in themselves' rarely have anyone, single, fixed, and unchanging meaning. Even something as obvious as a stone can be a stone, a boundary marker, or a piece of sculpture, depending on *what it means* – that is, within a certain context of use … [I]t is by our use of things, and what we say, think, and feel about them – how we represent them – that we *give them a meaning*. In part we give objects, people and events meaning by the frameworks of interpretation which we bring to them.

While the material and non-material attributes of the first layer in culture are easily visible, they are difficult to acutely decipher (Schein 1990a). Alvesson and Berg (2011, p. 104) suggest however that through studying the artifacts and symbols of an organisation it is possible to 'have a grip on the core of its culture, its emergence and above all, its functioning'. Organisational artifacts, including organisational heritage artifacts, express the 'deeper cultural circumstances' of an organisation with 'meaning and values created, reinforced, maintained and communicated through the artifacts' (Alvesson & Berg 2011, p. 103).

Schein's second layer of culture, also visible, are the espoused values and beliefs which Bradley (2000, p. 125) suggests represent 'preferences for alternative outcomes as well as a means for achieving them'. Scott-Findlay & Golden-Biddle (2005, p. 360) notes that 'values are the explicitly articulated norms, social principles, and ideologies considered to have intrinsic worth and importance within the organisation'. This are articulated through organisational philosophies, management strategies, strategic plans, and organisational value and mission statements all developed to set guidelines for behaviour, essential precepts that new employees are automatically encouraged to adhere to and follow.

The third and deepest layer, described as invisible, intangible, and usually tacit, are basic underlying assumptions. Shared by organisational members, assumptions are 'widely held, ingrained subconscious views of human nature and social relationships' (Parker & Bradley 2000, p. 127) that shape behaviours and tend to persist over time (Kotter & Heskett 2008). Assumptions 'are often so taken for granted that they are hard to articulate [and] are invisible to organisational members' (McDermott & O'Dell 2001, p. 77). Schein (1990a) contends that members are usually unaware of these values and assumptions unless challenged by people external to the organisation.

While culture manifests itself through observable artifacts and 'shared espoused values, norms and rules of behaviour', 'the essence of a group's culture' are the shared, basic underlying assumptions (Schein 2017, p. 32). To understand an organisations culture it is not only necessary to understand the basic underlying assumptions, but also the learning processes by which those assumptions evolved (Schein 2017). Martin (2001) further argues that researcher interpretation of organisational cultural layers may be influenced by the depth of analysis applied. A superficial study of interpretations and meaning may only reflect 'formulaic expressions of espoused values in a corporate values statement' whereas research aimed towards profounder meanings may expose deeply held personal values that take the form of hard-to-articulate, taken-for-granted basic assumptions (Martin 2001, p. 47). Martin (2001) disagrees with the notion that cultural artifacts and values are superficial, and argues that both may reflect deep assumptions, as meaning is entirely dependent on interpretation. In this way 'artifacts, values and assumptions do not necessarily reflect separable varying levels of depth' (Martin 2001, p. 47). The interdependence of cultural layers is 'evident in rites and ceremonies that combine various forms of cultural expression', and that rites and ceremonies make use of cultural forms such as artifacts, symbols and settings 'to heighten the expression of shared meanings appropriate to the occasion' (Trice & Beyer 1984, p. 654).

Within wider anthropological settings, 'human attitudes, values and behaviours are limited not only by our genetic predispositions – which often are difficult to identify – but also by our experiences during enculturation' (Kottak 2016, p. 304). Many values are in fact taught to new members during the early socialisation process and may occur as a result of diverging organisational subcultures within an organisation. Shared values and beliefs influence organisational member feelings, thoughts, orientation and motivations, as do symbolic structures, actions and situations (Alvesson & Berg 2011; Furnham & Gunter 2015). As such, culture is also individually imagined in that, like identity and image, 'is grounded in a slightly different set of individual value orientations, professional positionings, life experiences, and class, race, gender, and age differences' (Harrison 2000, p. 427). Organisational culture can then be viewed as 'heterogenous, comprising multiple layers of identities and several diverse communities' (Morgan & Ogbonna 2008, p. 40). It is an 'amalgam of many cultures', or subcultures, and it is the interaction 'of these subcultures that influence the emerging pattern of values that is commonly described as organisational culture (Morgan & Ogbonna 2008, p. 42).

Health care settings like large hospitals, with numerous professional and non-professional streams, are 'notoriously varied, fractured by specialty, occupational groupings, professional hierarchies, and service lines' (Mannion & Davies 2018, p. 2). Hospitals then are dynamic systems 'made up of multiple, complex, and overlapping subgroups with variably shared assumptions, values, beliefs, and behaviours' (Mannion & Davies 2018, p. 2). Numerous subcultures exist and persist across time within a hospital (Scott et al. 2003). Further, cultural landscapes can 'at any one time be thought of as being populated by several generations who, in a sense, form different strata' (Byrne 2008, p. 162). As a consequence hospital cultures have at times been described as dysfunctional (Sovie 1993) and suffering 'epidemics of cultural shortcomings' (Mannion & Davies 2018, p. 1). Hospital cultures in particular can prove to be integrated, differentiated, or fractured as a result. These issues will be explored in the thesis in relation to the interaction and impact of heritage on the organisational culture of RPA Hospital. Hospital heritage is one artifact and organisational symbol that may bridge subcultures through providing an overarching single cultural narrative from which other narratives can both emerge and be constructed from.

To summarise, hospitals are complex organisations built on and grounded in constructions of identity, image, and culture. As social constructions, they are enacted daily in that 'any collective action requires a shared element of meaning' (Czarniawska-Joerges 1992, p. 33). Hospitals both 'have' culture and 'are' culture and consist of layers and intersections of multiple identities and organisational subcultures. Organisational members express comprehension of their organisational culture through organisational identity, which in part emerges, is constructed, and manifests itself through organisational artifacts, values and underlying assumptions (Hatch & Schultz 1997). This identity is 'grounded in and justified by cultural assumptions and values', and further, that 'symbols of organisational culture are sources of image-building material, and that the products of image building' are central components in the development of culture (Hatch & Schultz 1997, p. 360). Regardless of whether identity is central, distinctive and enduring (see Albert & Whetten 1985), 'shifting, precarious, dynamic and unstable' (see Gioia et al. 2000; Harrison 2000), or a complex mix of these attributes (see Brickson 2000; Pratt & Foreman 2000), 'rather than being ontologically secure, identity emerges from the process of organising' (Clegg et al. 2007, p. 498). Further, that organisational culture is comprised of multiple layers of individual and group identities and beliefs that may present as contradictory value systems within a single organisation (Morgan & Ogbonna 2008). RPA heritage is a central tenet of the organisation's culture and identity, and as such, should not be seen as a variable to measured and controlled, but instead viewed as a context within which interpretations of organisational identity are formed (Hatch & Schultz 1997, p. 357).

Cultural Heritage in Context

How heritage has been researched, studied and is understood varies tremendously across the literature. Waterton & Watson (2015) provide a comprehensive review noting perspectives have ranged from studying operational and management practices to those exploring heritage from a cultural practice perspective. From this, two key streams of literature have emerged, one orientated towards operational issues focussed on 'marketing, finance, human resources, hospitality, catering and retailing', and 'the other replete with social theory and critical analysis, in which these same activities are subjected to relentless deconstruction' (Waterton & Watson 2015, p. 6). Both investigative perspectives offer value to this thesis as perceptions of heritage value within an organisation can be viewed from both an operational lens and a socio-cultural lens. They present heritage as knowledge, and as knowledge, heritage 'constitutes both economic and cultural capital', and is 'simultaneously a cultural product and a political resource' (Graham 2002, p. 1015; Graham & Howard 2008, p. 5). Heritage is then also a 'resource of power and justification in conflicts over social justice and access to social and economic resources' (Smith 2021, p. 259). As such, historic sites and cultural built heritage offer a store of social values that require preservation and enhancement if the social capital of a specific society is to be sustained or increased (Riganti 2003). This framing can then be extended to organisations with significant material heritage such as the one under investigation in this thesis. There has been no meaningful exploration of heritage in hospitals beyond exploring the history of hospital architecture (see Wagenaar 2020; Willis et al. 2018) and the use of portable heritage for an heritage in health intervention program (see Thomson et al. 2012). The purpose of this chapter is to outline conceptions of heritage and how they were developed across time, to explore the contested nature of these conceptions and to analyse the various cultural heritage evaluation instruments that have to date influenced perceptions of heritage in Western societies. This will support the findings that emerge from the investigation into the value of heritage as situated within a colonial built and run institution.

Defining Cultural Heritage

Cultural heritage is an umbrella term that encompasses material and non-material attributes of a culture, society or community of people that are bestowed to future generations, and also 'refers to a contemporary society's use of the past' (Blake 2000; Nilson & Thorell 2018, p. 10). Heritage however is viewed as ubiquitous, ambiguous and never certain (Harrison 2013), and is a contested concept, regarded as inherently dissonant (see Graham 2002; Lumley 2005; Smith 2006; Tunbridge

& Ashworth 1996) meaning it can't be conceptually agreed upon, nor is there consistency surrounding its meaning (Graham 2002).

Early representations conceptualise heritage as a construct that embodies the notion of property, ownership, 'inheritance and handing on', while also symbolising concepts of a duty to preserve and protect (Prott & O'Keefe 1992, p. 307). The key difference between cultural property and cultural heritage being that property stresses possession and objects, while heritage stresses the inheritance process (Prott & O'Keefe 1992). Harrison (2013) contends that although notions of heritage as things and traditions from the past have long been with us, the numerous ways in which heritage is defined, managed and understood are distinctive to our late modern period. There is much assertion that conceptions of heritage have emerged from and been dominated by a Euro-Western epistemology (see Harrison & Hughes 2010; Munjeri 2004; Smith 2006). By the late 20th century, these assumptions, which underpinned the development of the heritage sector, had largely been 'undermined in that the value [of heritage] was now viewed as socially constructed and open to critique and interpretation' (Jones & Leech 2015, p. 32). The discourse surrounding heritage has since moved beyond early, more traditional conceptions focussed 'narrowly on architectural and archaeological preservation' of material sites to be understood today as a socio-political construct (Larsen & Logan 2018, p. xv).

Su (2018, p. 920) states that within the Critical Heritage Studies field, modern assessments of heritage define it 'as a set of values, meanings and identities that are dynamically recognised, constructed, engaged and transmitted by present-day people and communities in the process of heritage-making' (see Graham 2002; Harrison 2013; Harvey 2001; Smith 2006; Waterton & Watson 2015). Heritage is then a multilayered discourse and 'a performance of visiting, managing, interpretation or conservation that embodies acts of remembrance and commemoration while negotiating and constructing a sense of place, belonging and understanding in the present' (Smith 2006, p. 66). Within such framings, heritage then is no longer viewed as a thing but as a living social process that Kirshenblatt-Gimblett (2016, p. 178) argues is a 'mode of cultural production that has recourse to the past and [that] produces something new'.

Heritage can also be viewed as the past made present and is 'concerned with the ways in which very selective material artifacts, mythologies, memories and traditions become resources for the present' (Graham 2002, p. 1004). Harrison (2013, p. 7) extends this interpretation suggesting 'our futures are imagined and made possible through the pasts which are produced through heritage in our present'.

Heritage then is sustained through a continuous process of interpretation (Kirshenblatt-Gimblett 2004), and can be selected or discarded as per the demands of a changing society (Graham 2002). As modern cultures are more fluid and changeable, people are no longer inheritors or passive recipients of culture, but are instead, 'active owners and modifiers of culture' (Byrne 2008, p. 162). What is inherited by the living is 'reinterpreted in the eyes of their own experience', with 'heritage significance or meaning' then continually reinvented through ongoing processes of significance reproduction (Byrne 2008, p. 162).

Heritage is therefore as much about forgetting as it is remembering the past and can be 'interpreted differently within any one culture at any one time, as well as between cultures and through time' (Graham 2002, p. 1004). Further, that 'each of us has two heritages, a vertical one that comes to us from our ancestors, our religious community and our popular traditions, and a horizontal one transmitted to us by our contemporaries and by the age we live in' Maalouf (2011, p. 121). Maalouf (2011, p. 121) notes horizontal heritage as the more influential which he suggests is 'not reflected in our perception of ourselves, and [yet] the inheritance we invoke most frequently as the vertical ones'.

Heritage and the past provide both benefits and burdens. Graham et al. (2005, p. 33) summarises these as four key traits where:

1. heritage conveys the respect and status of antecedence and underpins the idea of continuity.
2. heritage objects and sites acquire cultural significance and thus become symbols by connecting the past with the present in an 'unbroken trajectory'.
3. 'the past provides a sense of termination'.
4. the past offers a sequence and lineage in which we position ourselves as a part of that continuity.

The benefits of heritage include familiarity, guidance, continuity, affirmation, possession, and identity with numerous overlaps and intersections (Lowenthal 1985, 2015). Societies use heritage and the past to invoke timeless values and unbroken lineages (Lowenthal 2015, p. 92), that can validate the present by 'restoring lost or subverted values' (Graham et al. 2005, p. 33). It can however also become an obstacle and a burden as 'the sheer presence of the past can damage the present' by inhibiting and restricting change and progress, and repressing optimism and creativity

(Lowenthal 2015, p. 133). Lowenthal (2015, p. 144) argues that 'only a past seen as truly over can cease to be a threat', therefore time and space are required in order for the present to feel secure. The term heritage has essentially evolved 'to include almost any sort of intergenerational exchange or relationship, welcome or not, between societies as well as individuals' (Graham et al. 2000, p. 1).

Heritage Contested

Central to the contestation surrounding the meaning of heritage is that of the shift from heritage viewed solely as objects, that of material artifacts, monuments, and sites, to a view that interrogates 'its social and cultural context and significance' (Waterton & Watson 2013, p. 550). Heritage was no longer considered as static objects with limited value derived from 'the authenticity of physical fabric' (Logan 2000, p. 61) but instead argued as a social process and living thing, with intangible non-material qualities. Further, scholarship began to challenge modern notions of heritage authenticity suggesting heritage bodies 'favour a Western fetishism of the monument and stone construction, which could easily deny the value of vernacular heritage, in which we may discover a locally situated life of authenticity' (Wu & Hou 2015, p. 41). As a result of Western Eurocentric value perceptions, 'highly symbolic [material] objects take precedence at the expense of popular forms of cultural expression or historical truth' (Munjeri 2004, p. 13). Monumentality or expressions of what the West defines as fine artistry have often led to the neglect of spiritual 'connection to place', and to the less overt signs of our past, 'which can be of great emotional value to ordinary people' (Sullivan 2004, p. 50). The Khmer city of Angkor in central Cambodia provides an excellent example of the limited way in which Western centric perceptions of heritage value are applied (Sullivan 2004). Angkor's heritage listing, in response to the universal values it represents, do not include or acknowledge any ongoing local community traditional or religious connections. Further, Sullivan (2004, p. 50) maintains that locals have been excluded from 'management decisions and instead have laboured under the direction of foreign experts, with longstanding local farming traditions and rights largely restricted in the interests of the conservation of World Heritage values'.

Smith (2006, 2015) has notably argued that there is a dominant 'authorised heritage discourse' (AHD hereafter) that prevails within Western heritage frameworks, and that largely;

> 'focusses attention on aesthetically pleasing material objects, sites, places, and/or landscapes that current generations must care for, protect and revere so that they may be passed to nebulous future generations for their education, and to forge a sense of common identity based on the past' (Smith 2006, p. 29).

The AHD as a consequence, 'defines who the legitimate spokespersons for the past are' (Smith 2006, p. 29), and again espouses and legitimises largely Western Eurocentric perceptions, at the exclusion of other voices (see Harrison 2013; Smith 2006; Smith & Akagawa 2009). Further, that notions of heritage and heritage conservation emerge from what Sullivan (2004, p. 49) calls 'Western Dreaming', in that conceptions of world heritage are products of Western values and systems which are concepts of Western civilisations that we [in the West] take for granted. These definitions, being Eurocentric by design, offer expressions of meaning that are restrictive and constrictive in nature, propagating narratives that are largely 'Western national and elite class experiences' of white men (Smith 2006, p. 299).

Smith (2015, p. 3) has argued with respect to AHD that all heritage is by nature intangible, and that conceptions of heritage need to be reframed to 'deprivilege' the 'self-evident form' and by extension the very 'essence of heritage'. Heritage cannot simplistically be divided into two conceptual streams of the tangible (material) and intangible (non-material). In other words, frameworks need to dematerialise heritage as a thing to be applied but rather as an embodiment of values that exist. Within this framing, heritage can then be viewed as both a product and a process, and as an idea is mutable, temporal, and constantly evolving. Heritage can then also be more usefully conceived as a cultural (socio-political) process in which cultural and social meanings are negotiated, made, remade and/or rehearsed (Smith 2006).

The two-ontology view of cultural heritage presents conceptual problems in that suggesting ICH is constantly recreated as incorrect (Munoz-Vinas 2023, p. 162). Some elements of ICH such as a poem or digital photograph as examples, are moments in time that cannot be recreated, and further that some tangible objects contain intangible values but are tangible heritage by nature (Munoz-Vinas 2023). Munoz-Vinas (2023, p. 162) proposes a four-ontology cultural heritage model that 'distinguishes three categories of true heritage plus an additional category (performance) that can be considered heritage through a semantic displacement':

1. tangible, material objects.
2. mindsets or embodied knowledge: sets of ideas, skills, or beliefs that only exist in the mind or bodies of the individuals;
3. datasets: information that can exist in non-human material supports, such as a paper sheet, a computer disk drive, or a CD; and

4. performances.

Munoz-Vinas (2023, p. 162) however contends that ‘performances’ are not true heritage as they lack the central feature of heritage, which is the ability to be passed down to others. They can be re-enacted, which constitutes another performance, but ‘only the mnemonic aids [of that performance] can be passed down’ (Munoz-Vinas 2023, p. 161). Smith (2006, p. 263) however argues that a festival, as example, ‘is a performance of heritage that reworks, asserts and creates memories’ which construct messages that are ‘continually negotiated and remade with each festival’. Heritage in this sense is not static, is mutable, is dynamic, and is passed down.

There is further argument as to why heritage should not be viewed as a product, or ‘thing’ but more a process as ‘performance’ (Haldrup & Bœrenholdt 2015, p. 52). Haldrup and Bærenholdt (2015) approach heritage-as-performance arguing meaning emerges from social practices and engagement. In other words, heritage is fluid and dynamic with meaning emerging from people’s active performances ‘of, at and with’ heritage. Smith (2006, p. 3) uses the example of Stonehenge in England as identifiable material heritage that does not contain inherent value in that it is essentially ‘a collection of rocks in a field’. What gives those rocks value and makes them heritage are the cultural processes and social interactions that occur around them and in response to them (Smith 2006). A collection of stones become symbols of local cultural events with spiritual and social value as a result of these processes and interactions.

This conception of heritage aligns with Kirshenblatt-Gimblett’s (2016, p. 178) view that everyday cultural assets, or what is referred to as ‘habitus’ by Bourdieu (1986), contain the potential to become heritage. Kirshenblatt-Gimlett (2016, p. 178) notes habitus here refers ‘to the taken for granted, while heritage refers to the self-conscious selection of values, objects and practices’. What was once valued only as cultural property or ‘habitus’ and a disposable financial asset transforms to become a cultural artifact containing spiritual relevance and a source of identity. With the implication that significance occurs through the construction of emotional connection, new relationships are consequently formed with objects, places, and spaces that in turn see a new level of value emerge. Such manifestations of value, experienced by those who possess the heritage may reflect larger underlying cultural assumptions. These assumptions may diverge as like art, a cultural object can ‘disclose significations at different levels according to the deciphering grid applied to it’ (Bourdieu 1993, p. 97). Heritage can be viewed through an anthropological, a political, legal, or a religious lens. Each lens will provide a perspective and attach a set of values that are aligned to the

field from which is it viewed. Modern views of heritage conceive it as offering commercial, political and social value, and is often used 'in the context of debates and protests about things and practices that are considered to be threatened or at risk' (Harrison 2013, p. 7) This values-based approach to heritage is again reliant on the deciphering grid applied.

Whilst a value-based approach is the 'most preferred approach to heritage' management within Western Eurocentric conservation agencies, Poulios (2010, p. 170) argues that an alternate 'living heritage' framing is more suited in some other situations. Contention surrounds current living heritage theoretical frameworks in that a values-based approach is again based on material heritage as a non-renewable resource, thereby failing to embrace traditional management processes that may not prioritise non-material values (Poulios 2010). Poulios (2011, p. 151) argues that a living heritage site should be seen 'as a heritage site that maintains its original function as continually reflected in the process of its spatial definition and arrangement, in response to the changing circumstances in society at local, national and international level' (Poulios 2010, p. 175). In other words, a living heritage site should be based on continuity of a local community's presence, continuity in the function of the site, and finally, continuity in the maintenance and management processes of the social and physical space.

The complexities then surrounding cultural heritage evaluation frameworks stem from negotiating the concepts of value and values, and the persistence within the heritage sector that values are intrinsic and/or instrumental. Mason (2002, p. 8) contents that heritage is 'multivalent' in that objects, sites and natural heritage can have numerous values ascribed to them. They are 'mutable' (Torre & Mason 2002, p. 3) across space and time, evolving with the changing social and economic frameworks in which they exist. Further contention then stems from the nature of the social-cultural or economic lens applied to heritage evaluation, one derived from Western Eurocentric epistemologies. As discussed in the next section, Eurocentric international conventions have traditionally 'focused on the identification and preservation of fabric' (De la Torre 2013, p. 157), with an 'intrinsic sense of worth' often attached to monuments and objects thus reframing them as historical documents and works of art (Jones & Leech 2015, p. 32). As a result, the connection between the presence of cultural heritage and its larger social, spiritual or symbolic value, as experienced by non-Western cultures is often overlooked (Harding 1999). Cultural economists for example, view heritage as a capital asset with economic value (Wright & Eppink 2016). Such limited framing 'fails to capture the dynamic, iterative and embodied nature of people's relationships with the historic environment in the present' (Jones 2017, p. 22).

The Development of Cultural Heritage Frameworks

To examine the value of cultural heritage at RPA it is necessary to explore the concepts of perception and value; in other words, understanding how organisational members view, recognise and value cultural heritage as perceived by them. To do this we must briefly explore the legal and social heritage protection instruments and frameworks that pertain to the recognition and protection of cultural heritage which ultimately guided how heritage in Western European cultures is perceived and has therefore come to be valued. Perception in this sense is 'the process by which an individual receives, selects and interprets stimuli to form a meaningful and coherent picture of the world' (Schiffman et al. 2005, p. 148). Perceptions involve 'the acquisition, storage, transformation and use of information' (Solomon et al. 2012, p. 44) and are built on and developed through prior knowledge (Brewer 2011). Values surrounding heritage have been passed through generations, with each generation seeing an iterative process of critical assessment and therefore alteration in meaning and interpretation. As this thesis explores heritage situated within a Western culture, with largely Western perceptions of value, what follows will assist in building a critical framework for understanding conception of heritage in the West.

As previously discussed earlier in the chapter, conceptions of cultural heritage have for the past century been largely focussed around materiality and the physical manifestations of cultures such as monuments, landscapes and artifacts (Ahmad 2006; Larsen & Logan 2018), captured 'in a single mode of being, or single ontology' (Munoz-Vinas 2023, p. 161). This focus on materiality occurred as a direct result of the introduction of frameworks and heritage management instruments established by international organisations like UNESCO (United Nations Educational, Scientific and Cultural Organisation) and ICOMOS (International Council on Monuments and Sites), and numerous other regional, national, and multinational organisations (Ruggles & Silverman 2009). These 'organisations promulgated a particular approach and a series of underlying [universal] values towards heritage, which are now part of a common, universal language of heritage management' (Harrison 2013, p. 8). To qualify for the World Heritage List under such frameworks, Jokilehto (2006, p. 1) notes heritage must 'meet the conditions of authenticity and integrity', and have 'outstanding universal value'.

Initially introduced to safeguard material heritage after World War Two, these heritage management instruments would instead frame how cultural heritage was defined, perceived and understood as a cultural phenomenon over the next fifty years (Ahmad 2006; Harrison 2013; Ruggles & Silverman 2009; Smith 2015). These conventions and instruments have primarily guided and underpinned how heritage has become understood and valued in Western civilizations. These

frameworks have been minimally applied to hospital-built heritage, but not movable heritage. It is therefore necessary to briefly explore the development of these heritage conventions and management instruments as relevant to the material under investigation in this thesis.

In the West, protecting heritage monuments in the name of national interest dates back to 1684 in Sweden and 1737 in Denmark, with Greece passing the first Ancient Monuments Act in 1834 (Chippindale 1983; Voudouri 2010). This act was the first in Greece to 'specifically designate all antiquities within the Greek state as the national property of all Greek citizens' (Tsiafaki & Katsianis 2021, p. 2), and was widely considered groundbreaking for the time (Voudouri 2010). The first legislation towards the recognition and protection of heritage in Britain occurred with the *Ancient Monuments Protection Act of 1882* (Saunders 1983). The act aimed to protect privately owned Roman and various other prehistoric remains under threat of destruction by reclassifying them as 'heirlooms' of national significance (Halfin 1995). It also aimed to impart the responsibility of protection on the owner and not necessarily the government, which would henceforth frame heritage as 'property' with a 'use value' and a 'symbolic value (Sax 1990, p. 1557).

The first significant global instrument that attempted to frame cultural heritage was the 1954 *Hague Convention for the Protection of Cultural Property in the Event of Armed Conflict* (Vecco 2010). The Hague Convention focussed 'on value rather than functional purposes' (Harding 1999, p. 299), noting heritage material as property with defined material value and ownership. This convention was then followed by the *International Charter for the Conservation and Restoration of Monuments and Sites* adopted by ICOMOS in 1965, known as the Venice Charter, which would frame heritage as historic monuments and sites (Ahmad 2006). The Venice Charter proved significant as for the first time people were seen as becoming 'conscious of the unity of human values', with monuments viewed as common heritage, and therefore there being a common responsibility and a universal duty to preserve, and 'hand them on in the full richness of their authenticity' (ICOMOS 1994).

These framings would then be reconciled in 1972 at the World Heritage Convention Concerning the Protection of the World Cultural and Natural Heritage (Ahmad 2006). The 1972 convention would continue to focus on the protection of material cultural and natural heritage, and remained limited in scope to material aspects of heritage associated with built and immovable heritage environments. As a result, heritage would be articulated as being one of two tangible or material things that people engage with: human created heritage and natural landscapes. This would however provide the first significant framework towards recognising wider conceptions of value.

Article One of the World Heritage Convention cites three key dimensions of cultural heritage: heritage as monuments, heritage as groups of buildings and heritage as sites expressly noting 'outstanding universal value from the point of view of history, art or science' and 'outstanding universal value from the historical, aesthetic, ethnological or anthropological point of view' (UNESCO 1972).

The first significant step toward recognition and management of movable cultural heritage occurred in 1978 when UNESCO formally recognised movable cultural heritage as cultural wealth requiring protection. This articulation of heritage greatly expanded conceptions beyond those movable objects restricted to museum collections and further expanded the notions of value. Movable cultural heritage, as defined by UNESCO (1978) are those objects both on land and under water that 'are the expression and testimony of human creation or of the evolution of nature and which are of archaeological, historical, artistic, scientific or technical value'. Such objects include antiquities, art, fossils, instruments, manuscripts, flora and fauna and numismatic objects (Commonwealth of Australia 2020).

The 1979 Burra Charter: The Australia ICOMOS Charter for Places of Cultural Significance, last updated in 2013, would be the first significant formal step towards addressing the limited material focussed framework surrounding heritage. The Burra Charter proposed the protection of the cultural significance of a site due to its aesthetic, historic, scientific, spiritual or social value (Australia ICOMOS 2013a, p. 2). It focussed on 'three aspects: conservation principles, conservation processes and conservation practice' (Ahmad 2006, p. 297). The charter was the first to recognise that heritage can stimulate 'the recognition of certain values' in people, and that these values should also be protected (Vecco 2010, p. 323). It was however not the intention of the Burra Charter to continue approaching heritage from a values-based perspective (Buckley 2019). Buckley (2019, p. 51) suggests the central message of the 'Burra Charter is that a very sound understanding of a place should enable the full array of its values to be articulated in a statement of significance, which is then the touchstone of policy development and decision making'. Further, the charter began to address the limitations imposed by earlier conventions on heritage frameworks by including 'all types of places of cultural significance including natural, Indigenous and historic places with cultural values' (Australia ICOMOS 2013a, p. 1). Where previously values were framed around the material and easily identifiable physical qualities of an object, now human perception and recognition of the deeper extrinsic, less identifiable values were recognised (Vecco 2010). Importantly, those values

were to be determined by both national and local interests, so would directly include the community of people from which it emerged.

In 2003 a significant shift in perception of cultural heritage protection and management occurred with the development and implementation of the Convention for the Safeguarding of the Intangible Cultural Heritage (ICHC hereafter) (UNESCO 2003). Munoz-Vinas (2023, p. 162) says 'this important shift added 'a second ontology to the category of cultural heritage, [that of] intangible cultural heritage' and 'expanded the notions scope' formally recognising the presence and importance of non-material heritage. Lixinski (2011) notes that one definitional issue with this convention lies in its duality as a concept. It is both dependent of material cultural heritage in that it acts as 'the underlying culture to any given expression, encompassing the processes, skills, and beliefs leading to the creation of tangible works' (Lixinski 2011, p. 83). While it is also an independent type of heritage, consisting of forms of expressions such as songs, dances and stories not fixated on or having emerged from material means (Lixinski 2011). As argued by Smith (2011) and reiterated by Buckley (2019, p. 50) all heritage, and their associated non-economic socio-cultural values are however intangible, and 'all meanings applied to heritage places are socially constructed and selected'. This duality will be examined in connection with the material objects under investigation in this thesis, however intangible, or non-material conceptions of heritage not directly associated with material heritage will not be examined in depth.

The remainder of this section will introduce and explore the various socio-cultural and economic value frameworks that guide interpretations and discussions of heritage. These frameworks can each be applied to heritage at RPA Hospital, a public organisation, with varying degrees of success.

Socio-cultural Value of Heritage

Central to the discussion of heritage value is that of the UNESCO World Heritage Convention articulated notion of outstanding universal value. Outstanding universal value is argued to be a 'relativist perception of values' derived from Eurocentric viewpoints to the exclusion of non-Western articulations (Labadi 2013, p. 11), and is viewed by some as 'incompatible with the essential diversity of human culture' (Cleere 2003, p. 29). Such frameworks suggest that some heritage contains universal value due to intrinsic and objective qualities that can be globally recognised as significant by all humans, 'regardless of socio-economic status, geographical origin or cultural frame of reference' (Labadi 2013, p. 11). Within this framing, for heritage to meet the criteria for outstanding

universal value it must demonstrate an agreed 'concept of value', 'test of authenticity', and 'conditions of integrity' (Jokilehto 2006, p. 2).

Jokilehto (2006, p. 2) suggests that authenticity is determined via three essential questions that include 'the creative process, the documentary evidence and the social context'. While no element should be viewed individually but in relation to the other, the third concept of social context is integral to this research, as the socio-cultural processes surrounding organisational heritage are multilayered. They include those enculturation levels and processes developed from the local and wider community imposed on the organisation since foundation, and those developed specifically from within the organisation.

Conceptions of heritage integrity are also significant to the exploration of heritage within the organisation that is the subject of this thesis. Heritage integrity regarding built heritage environments is divided into three typologies of 'social-functional', 'material-structural' and 'visual-aesthetic'. RPA Hospital contains heritage that meets each criterion in that it is a living heritage site. As stated by Jokilehto (2006, p. 3; 2008, p. 44):

1. Social-functional integrity provides the reference for the understanding of the meaning of the different elements in a built environment.
2. Material-structural integrity instead defines the present-day reality in the field, i.e. the elements that survive in today's historical condition from the evolving functions of the past.
3. Visual-aesthetic integrity… considers the condition within the nominated area, as well as its relationship with the setting.

Fadaei Nezhad et al. (2015, p. 95) notes 'the concept of integrity as a factor of sustaining values and significance of cultural heritage' across time and space. As heritage values are simultaneously applied to both material and non-material heritage, integrity requires 'continuing the physical structure of heritage' in addition to locally constructed socio-cultural and intellectual structures (Fadaei Nezhad et al. 2015, p. 103). Fadaei Nezhad et al. (2015, p. 95) further add that should the 'physical structures of integrity, and the qualities that constitute heritage significance continuity and stability shift', heritage significance would continue to be manifested through stability of social structures.

Su (2018) notes that while authenticity is a central theoretical concept to the heritage field, there is dispute surrounding how the existing definition should be expanded to include non-material heritage. Research has to date primarily linked notions of authenticity to material heritage 'which emphasises the intrinsic and static materiality of tangible heritage' (Su 2018, p. 920). When heritage is argued to be a cultural process rather than a product and outcome (see Harrison 2013; Smith 2006; Waterton & Watson 2015), then authenticity should 'be considered as a product in this heritage-making process, regardless of [being] tangible or intangible' in nature (Su 2018, p. 920). Furthermore, notions of significance, [authenticity and integrity], are purely human concepts that are fluid, complex and dynamic, shifting with and responding to society's multilayered, changing value system (Pearson & Sullivan 2013).

In relation to heritage, Jokilehto (2006, p. 2) suggests value should be perceived as 'a social association of qualities to things that 'are produced through cultural-social processes, learning and awareness'. Cultural heritage values are generally 'considered plural in recognition of the fact that heritage is considered significant for a range of different reasons' (Fredheim & Khalaf 2016, p. 467). Díaz-Andreu (2017) notes there are numerous classifications and typologies but the commonly referred to socio-cultural values accepted by the heritage sector include, but are not limited to, aesthetic, historical, scientific, social, spiritual and symbolic (see Figure 25):

1. **Aesthetic (artistic) value** identifies a 'unique and original creation of which the exceptional quality is universally recognized by competent specialists in the fields concerned' (Jokilehto 2008, p. 11).
2. **Historic (commemorative) value** identifies the novelty or uniqueness of the object or place, the degree of importance regarding the influence it exercises in time and/or space, and its importance towards the comprehension of a specific historic event (Jokilehto 2008).
3. **Scientific (educational) value** identifies those ethnological, anthropological, geological or architectural features that provide research possibilities, and that can contribute to the knowledge and understanding of an object or place (Jokilehto 2008; Lipe 2009).
4. **Spiritual (religious) values** are those religious or sacred meanings that emanate from beliefs and teachings from organised religion, which can include secular experiences of wonder, understanding and enlightenment (Mason 2002; Throsby 2002).
5. **Symbolic (communal)** value reflects or conveys the shared meaning of a place or object for those who relate to it (Jones & Leech 2015).

6. **Social value** refers to social cohesion, community identity, or other feelings of affiliation derived from specific locally connected heritage (Mason 2002).

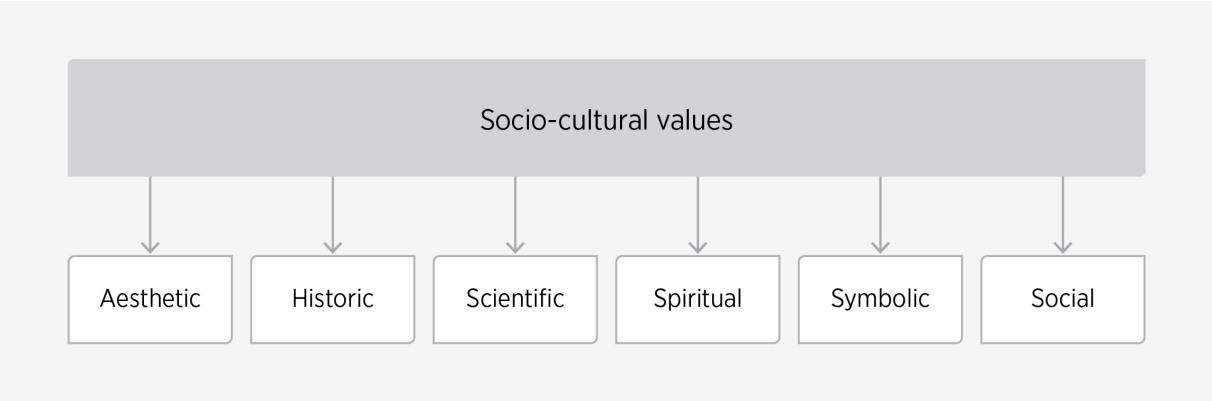


Figure 25 Socio-cultural values (source: Author, adapted from Throsby, 2002)

Li (2019, p. 102) notes that 'regardless of the difficulty in finding concordance on the nomenclature of different heritage values, the distinction of socio-cultural value typologies from the traditional historic, artistic, and scientific major three is generally agreed upon in the heritage field. While historic, artistic and scientific values are 'rooted within the notion of material integrity', (Li 2019, p. 102) social and cultural values, in particular are a complex concept, variable in nature and interpretation (Jokilehto 2006; Pearson & Sullivan 2013). Pearson and Sullivan contend that In general terms, social value entails standards that are set by individuals or a community of people that shape and operate as guiding principles in life (Tsirogianni & Gaskell 2011). They 'are a means by which natural groups define the social order—what is acceptable and what is not acceptable' and 'which impinge on individual choices but are collectively generated, sustained and changed' (Tsirogianni & Gaskell 2011, p. 2). Jones (2017, p. 21) defines social value in relation to heritage as 'a collective attachment to a place that embodies meanings and values that are important to a community or communities, including people's sense of identity, belonging and place, as well as forms of memory and spiritual association'. These values may also encompass political, national or other qualities of cultural importance. Jones and Leech (2015, p. 29) argue that as 'social value is a product of practice, engagement, meaning, and memory', it is 'unlikely to be obvious in the fabric of a place or readily apparent to the outside observer'. Therefore experience of an historic environment is essential to creating forms of social value (Jones & Leech 2015).

The Burra Charter Practice Note on Understanding and Assessing Cultural Significance (Australia ICOMOS 2013b, p. 4) explains the use of social value as applied to cultural heritage according to three specific dimensions:

1. Is the place important as a local marker or symbol?
2. Is the place important as part of community identity or the identity of a particular cultural group?
3. Is the place important to a community or cultural group because of associations and meanings developed from long use and association?

These dimensions encompass the ways in which the historic environment provides a framework for 'identity, distinctiveness, belonging and social interaction' (Jones 2017, p. 22). They also demonstrate that cultural heritage values cannot necessarily be viewed as singular as they intersect and overlap within the complex cultural or socio-political contexts in which they exist. Value is not then an intrinsic quality but rather that material heritage 'is the bearer of an externally imposed culturally and historically specific meaning, that attracts a value status depending on the dominant frameworks of value of the time and place' (Gibson & Pendlebury 2016, p. 1). While spiritual values are 'beyond forms', it is a part of the human condition that they must still be experienced through a 'specific form' (Bianca 2001, p. 21). Bianca (2001, p. 21) argues that 'without the interplay between a transcendent vision and a tangible human embodiment, "culture" will remain either meaningless or unproductive, and so will the creation of the built environment'.

Economic Value of Heritage

While the economic value of RPA heritage is not under investigation in this thesis, notions of use and non-use value are central components of heritage economic value and therefore are germane to understanding organisational member perceptions of value. Cultural economists view cultural heritage differently to that of heritage professionals who are focussed on the socio-political values of heritage. Cultural economists view heritage as a capital asset and commodity with monetary value that has intrinsic, extrinsic and/or instrumental value. Known as cultural economics, this sub-discipline of economic theory provides meaningful and quantifiable value to material cultural heritage through determining use and non-use values and aims to determine the Total Economic Value (TEV) of cultural heritage. TEV is the sum of both use and non-use values and reflects 'a variety of human motivations, as well as aggregating local values to attain a global value' (Nunes & Nijkamp 2010, p. 20) derived from 'physical existence as a public good or asset without regard to cultural worth' (Throsby 2002, p. 103).

Heritage use values are viewed as consumptive (direct use) and non-consumptive (indirect use), which refers to the goods and services they generate (Mason 2002; Rypkema 2012). Examples of direct use value include use for income, as industrial, residential, or commercial rental space, and through real-estate market exchange where heritage-listed buildings are sold as a product (Rypkema 2012; Throsby 2007). Another direct use value occurs within the heritage tourism sector, were the physical visitation and utilisation of a site or built heritage generates profit and supports the value of tourism (Lipe 2009; Poor & Snowball 2010).

The indirect-use value of heritage contributes to 'environmental and aesthetic quality, national identity, community image and self-esteem, and social interaction' Rypkema (2012, p. 10). Examples include the proximity of built heritage or a heritage site to non-heritage real-estate, which may impact on surrounding property prices (Throsby 2007), or when a real-estate property 'yields higher rents than other similar buildings by virtue of heritage status' (Rojas 2012, p. 146).

Non-use values, also called passive-use values, have to date been categorised as 'attributes of cultural heritage that are classifiable as non-rival and non-excludable' public goods, and as a consequence cannot be explored through usual market processes (Hutter & Throsby 2008; Throsby 2007, p. 3). The non-rival characteristic of public goods means that more than one person can enjoy or consume that good without diminishing another person's enjoyment (Navrud & Ready 2002). This sits in contrast to rival excludable goods like for example, the Mona Lisa in the Louvre Museum, where too many consumers can alter the individual experience, and as the Louvre charges a fee to view it, can be removed from public viewing spaces. Most public goods are non-excludable as users cannot be kept from engaging with a public good. It is not possible to exclude users from enjoying the 1882 heritage listed foyer RPA as it is a public good open twenty-four hours a day, seven days a week. The classification becomes further blurred in that some public goods are excludable and some private goods non-excludable under certain circumstances. For example, it is possible to exclude users from visiting the Temple of Karnak in Luxor, Egypt, as payment is required to enter the site, but not possible to exclude them from externally viewing the sculptures and architecture from the street.

Non-use values have been disaggregated into many varied typologies that are closely aligned to socio-cultural values: option-use value, formative value, entertainment value, representation value, transformational value, altruistic value, social value, historical value, authenticity value, symbolic value, spiritual value, philanthropic value, bequest value and existence value (Hutter & Throsby

2008; Kling et al. 2004; Mitchell & Carson 1989; Poor & Snowball 2010; Rizzo & Throsby 2006). The most commonly recognised hierarchy elevates existence value, bequest value and option value as and key elements while the remaining categories cascade as characteristics within these dimensions (Rojas 2012; Throsby 2007) (see Figure 26).

1. Existence value: where an individual values cultural heritage because it exists (Throsby 2007).
2. Option value: a desire to preserve heritage so as to leave open the option for future use (Throsby 2007).
3. Bequest value: where an individual desires to pass on heritage assets to future generations (Throsby 2007).

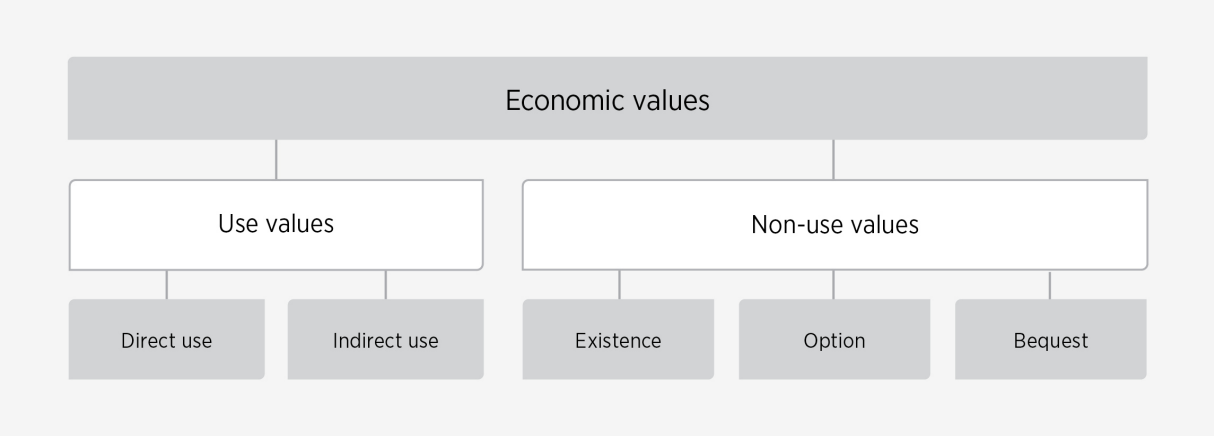


Figure 26 Economic Values (source: Author, adapted from Throsby, 2007)

Throsby (2000) notes that unlike regular commodities containing market measurable goods and services, a significant proportion of cultural heritage value resides beyond the traditional market place with non-market value, or non-use value. Some practitioners aim to go beyond this economic focused methodology to address 'the multi-functional and multidimensional nature of cultural resources' (Mazzanti 2003, p. 585). Instead of viewing heritage as a capital asset, Throsby (1999, p. 3) suggests it could be better articulated as 'cultural capital', linking both the economic and socio-cultural value of heritage under one framing. Throsby (1999) proposed a new understanding of cultural capital, one differentiated from previous articulations such as that proposed by Bourdieu (1986) which is understood as human capital within economic theory. This conception of cultural capital embodies the relationship between socio-cultural and economic value, and would 'formalise the role of such phenomena in cultural and economic affair' (Throsby 1999, p. 4).

Fredheim and Khalaf (2016, p. 476) additionally argue value-based typologies are an incomplete and inadequate understanding of values, and as such there is 'lack of an effective language to identify and communicate heritage'. They have proposed a simpler and more precise framework suggesting that value judgments be conceived through three stages which:

1. Identify features of significance that communicate what heritage is.
2. Identify aspects of value that explain why each feature is significant and worthy of conservation.
3. Identify qualifiers of value that justify why some features should be prioritised in conservation efforts over others.

These three stages offer a process that identifies, elicits and interrogates interpretations of heritage and significance, that can be gathered and organised into actionable information to become more inclusive and specific (Fredheim & Khalaf 2016).

Comparing Value Frameworks

The types of heritage frameworks thus far discussed can each be applied to heritage at RPA Hospital with various degrees of success. Determining the economic value of RPA heritage is out of scope in this thesis, however, acknowledging the framework of TEV is important as viewing heritage from a use and non-use perspective is central to understanding organisational member perceptions of value within a living heritage site. Those non-use existence and inheritance values are directly aligned with those values illustrated in figure 2. The aesthetic, spiritual, social, and historic qualities of RPA heritage are all non-use existence values that constitute components within socio-cultural value. The option and bequest values are extensions of those notions concerning the duty and responsibility to preserve heritage for future generations. Where non-use values become conceptually blurred occurs with the living and engaged nature of the Hospital's heritage. The varying types of heritage discussed in Chapter 2, excepting those held in archival storage, are widely engaged with daily. This engagement is as meaningful as walking through various spaces during the course of a day, or as complex as having to navigate the difficulties of modern healthcare in heritage aged infrastructure. Suggesting there are use and non-use values proposes heritage as either/or in that it is valued for instrumental use as an organisational tool or is valued for its intrinsic intangible qualities. As

identified in the organisational identity and organisational culture sections of this chapter, they are in fact deeply interrelated and inseparable.

Examining RPA organisational heritage through a social-functional, material-structural and visual-aesthetic integrity and authenticity lens poses additional limitations as it stresses built heritage and those movable objects that are more closely aligned to objects produced through a creative process such as statues and artworks. It excludes those mundane organisational objects that do not necessarily meet notions of universal value but contain qualities that constitute locally situated values important to organisational members. Those values defined in the Burra Charter most effectively represent the diversity and complexity of heritage at RPA Hospital. Those values that connect the material focused values with the non-material socio-cultural values that both are constructed and that emerge.

Organisations, Materiality and Heritage

An exploration of the literature suggests few organisations fully understand how heritage functions as an organisational tool. Urde at al. (2007, p. 11), note that 'having a heritage does not in itself create value, only the opportunity to do so', and as such, few organisations adequately investigate and recognise how heritage can be used to add value to organisational culture and identity, or be operationalised as a strategic asset. Watkiss and Glynn (2016) further contend that most research centres around the role of materiality as a driver of organisational identity construction. This confines research to exploring organisational artifacts as tools that communicate organisational character or image, and organisational performance as a source for providing 'competitive differentiation' (Yu et al. 2018, p. 1). Organisational image are those manifestations of corporate identity that include the ways in which an organisation presents itself though branding and strategy, logos, colours, designs, architecture and buildings (Bonti 2014; Ravasi et al. 2019). These limited conceptualisations frame artifacts as tools projected towards external audiences and are often surface manifestations of identity that are temporal and transitory in nature. They do not explore or explain how materiality and artifacts shape, affect, and reflect the deeper layers of culture and identity within an organisation. As such, organisational cultural heritage, which includes corporate heritage, holds deeper meaning and is transtemporal in that it connects the past, present and future 'in meaningful and relevant ways in the present' (Brunninge & Hartmann 2019, p. 230). It therefore should be viewed as an organisational artifact subset as it sits apart from what organisational theorists traditionally conceive organisational artifacts to be.

Organisational Artifacts

The term 'artifact' is an all-encompassing term that can contains several meanings and interpretations. The etymological meaning of artifact as explained by Gagliardi (2017c) is: *ars,* art + *factum*, thing made. Broadly defined, this means any object created or modified by a human culture thereby constituting material culture and artifact. A further definition sees an artifact as containing 'three dimensions: (1) a *product* of human action which exists independently of its creator; (2) *intentional,* it aims, that is, at solving a problem or satisfying a need; (3) *perceived by the senses,* in that it is endowed with its own corporality and physicality' (Gagliardi 2017c, p. 3).

Organisational artifacts are objects, patterns and symbols manufactured by people that facilitate culturally expressive activities (Trice & Beyer 1984). They are perceived by the senses, and have certain intentions aimed at satisfying a need or goal (Gagliardi 2017d), and both facilitate and limit organised actions (Alvesson & Berg 2011, p. 80). Rafaela and Pratt (2013c) argue artifacts can be viewed and understood as artifacts-in-practice, artifacts as demonstrating instrumental and aesthetic value beyond symbolic dimensions, and artifacts as visual markers and identity formation tools. When viewed within a distinct socio-cultural setting artifacts assist with interpreting and defining the surrounding space, and other objects within it. Space on one hand defines how artifacts engage, interrelate and affect one another, and on the other hand, the perception of space is linked to the perception of the objects (artifacts) within it, which ultimately frame and define the space (Gagliardi 2017c). By simply walking around an organisation noting its material artifacts and use of space, much can be immediately learned about an organisation's culture and identity (Ott 1989). Schein (2008; 1990a) however, notes that artifacts are usually the most visible, and often most superficial manifestation of organisational culture and so offer limited information.

Organisations care about their physical space investing large resources towards planning, design, and construction to ensure the organisational operational objective is best supported (Berg & Kreimer 2017). Basal and Knox-Hayes (2013) add that organisations are 'socio-material because the social and material are mutually constituted'. Artifacts and space both offer material and symbolic resources that can guide and support, or disrupt operational success (Gagliardi 2017b). Together they reflect 'cultural quiddity' and represent constitutions of communication and engagement built up and developed over time (Gagliardi 2017a). Meaning and value surrounding artifact engagement can however shift as a result of space and time. Materiality being those 'properties of the artifact that do not change from one moment to the next or across differences in location' (Leonardi 2012,

p. 29). Leonardi (2012) however notes the uses and perceptions of value surrounding those properties can greatly change as a result of changes in socio-cultural values.

Artifacts are also material manifestations that encode social meaning (Bechky 2008), and by extension organisational meaning. Ajmal and Helo (2010) suggest these dimensions are reflected within workplace organisations in three different ways: as expressions of employee experiences, as inspirational or non-motivating workplace components, and as member guidelines for stability or change (Dandridge et al. 1980). Members also use artifacts as tools and instruments to communicate and act through, although they are usually unaware of their symbolic influence (Gagliardi 2017a), or their importance to daily organisational routines. As a result, 'artifacts have great potential as a tool for teasing out organisational dynamics that might otherwise be hard to trace' (Bechky 2008, p. 3).

Context is important to the study of artifacts within organisational settings as artifacts assume multiple meanings within an organisation and are ubiquitous in organisational life (Rafaeli & Pratt 2013c). Bechky (2008, p. 4) further adds that artifacts 'draw attention to social constructions of organisations, the influence of work processes', organisational dynamics and 'the multiple interpretations held by organisational members'. Artifacts:

1. enact group membership and status in organisations.
2. signify and influence identity in organisations.
3. construct and embody organisational knowledge.

Kaghan and Lounsbury (2006, p. 260) argue that 'artifacts are imbued with an institutional residue that shapes how artifacts are constructed, used, and understood'. As a consequence they both uphold and reinforce institutional understandings, while also embodying contradictory social meanings (Fiol & O'Conner 2006). Through understanding artifact origin, characteristics and use, we can determine the extent to which artifacts are 'emblems of a socially constructed world' (Gagliardi 2017a, p. vii).

Heritage and Artifacts as Symbols and Actors

To reiterate, heritage is a multilayered performance of knowledge including acts of forgetting and remembering, and is both a cultural process and product, and a political resource (Graham et al.

2005; Smith 2006). It is negotiated and constructed within 'specific social and intellectual circumstances' (Graham et al. 2005, p. 32), offering a socio-political and economic function (Graham 2002). Heritage then can also be 'used' as a tool and a lens through which socio-political and economic characteristics of a community or organisation can be framed and explored, and through which 'a range of struggles are negotiated' (Smith 2006, p. 7).

That heritage at RPA is diverse and abundant has been well established in Chapter 2, however exploration as to the intent of executive leadership and management teams surrounding preservation and use of heritage as symbols and actors, and by extension the value that heritage presents will offer insight into wider conceptions of value. Explorations of artifact use - abundance, diversity, and placement - will also support investigations into organisational member perceptions of value as 'inherent to visual symbols is the context in which they are placed and the environment by which they are affected' (McDowell 2016, p. 39).

Organisational symbols are diverse and include the types of furniture and hardware purchased, the types of art and heritage presented, building design and modes of communication. Yanow (1998, p. 215) contends that built spaces can provide emotional narratives that 'use spatial vocabularies that communicate meaning' and 'are at once story tellers and part of the story being told'. For example, the chairs purchased for a hospital waiting area represent symbols both as individually selected choices, and in the way the chairs are spatially arranged, as are the types of artworks displayed, and the use of heritage infrastructure. Through situational manipulation artifacts can be used to communicate values, beliefs and feelings (Schein 1990b), and double as settings for organisational acts 'through which organisational meanings are communicated' (Yanow 1998, p. 215). This manipulation further extends to the use of artifacts as material symbolic reminders of an organisation's history and legacy. The very presence of cultural heritage, particularly those Western conceptions of heritage such as monuments and sites, cultural built heritage either in use or adapted for re-use, or entire heritage precincts, have been shown to impact those that engage with it.

Central to the issues surrounding Western conceptions of universal heritage value is that values are static and can be dissociated from local interests (Smith 2006). Wang and Aoki (2019) found that perceptions surrounding heritage built environments in China caused multidimensional and paradoxical value orientations. Due to the inherent qualities of heritage aged infrastructure, those that engaged with it perceived it as negatively imposing itself upon daily life through degradation and through its unsuitable historic design. By extension, hospitals that exist within heritage buildings

may experience conflicting socio-cultural value perceptions, and further that these perceptions may lie in direct opposition to economic value perceptions. Hospital staff members that are focussed on patient health care may experience a reduced enthusiasm towards maintaining or caring for their heritage listed environments, as it may detract from and interfere with medical best practice.

Redevelopment and sustainable planning have also been demonstrated as important when altering the built landscape of areas with high concentrations of built heritage (Tweed & Sutherland 2007). When heritage defines the character of an environment, changes may alter locally orientated connections and cultural identity. Tweed and Sutherland (2007, p. 68) found that 'the built environment exerts a major influence on citizens' everyday experiences, but interactions between people and the built environment are complex and operate at different levels'. From this research it was determined that built environments carry important intergenerational meanings that serve as repositories of cultural meanings (Tweed & Sutherland 2007), and that these meanings define and shape the identity of those locally engaged communities. Heritage then can be used as a powerful tool to shape or change that identity and the associated sets of behaviours that accompany it. The power to control through heritage ownership, use, accessibility and inaccessibility 'define who a particular group or community are and who they are not' (Smith 2006, p. 35). Control is then exerted over community behaviours, through influence on cultural practices and ultimately the central tenets of identity.

Implications of this then suggest that place attachment could also exist between organisational stakeholders and their heritage environments. Scannell and Gifford (2010, p. 1) note that 'due to the application of place attachment to many perspectives', a variety of definitions exists, however, place attachment in simple terms 'relates to the process whereby an individual's experiences with both the physical and social aspects of an environment results in the development of strong emotional bonds with that place' (Chen et al. 2016, p. 604). Place attachment is also viewed as a 'multidimensional concept with person, psychological process, and place dimensions' (Scannell & Gifford 2010, p. 2), or people-process-place tripartite three-dimensional framework. While initially associated with the home environment, neighbourhoods and landscapes, place attachment has been widely applied to the heritage tourism sector (Hoang et al. 2020), and offers a further avenue for investigation into organisational workspaces (Scannell & Gifford 2017). Like development and redevelopment, the impact of workspaces, design and change may influence 'peoples response to [that] new environment' (Inalhan & Finch 2004, p. 448).

The socio-political power of heritage to both influence and control individual and wider community behaviour occurs at multiple levels. Smith (2006, p. 53) notes that material heritage 'is itself a brutally physical statement, at least within the confines of the AHD, of the power, universality, objectivity, and cultural attainment of the possessors of that heritage'. The very notions of heritage and culture are at their core Western conceptions and creations (Dirks 1992; Harrison & Hughes 2010; Lowenthal 2015). Those who own heritage control access to it, income generated by it, and possess the 'power to control the production of knowledge about the past' (Harrison 2013, p. 109). These notions can be applied to the use and management of heritage at RPA. The stories told through heritage artifacts at RPA have to date largely been limited to those with the power to tell the stories, and those stories told are only those deemed appropriate to the current organisational climate or wider social atmosphere.

The presence of heritage across other anchor institutions such as university campuses has proven to offer both advantages and disadvantages surrounding cultural meaning. Through evaluating the student perspective of campus-built heritage at Rhodes University in South Africa, and St. Mary's College of Maryland in the USA, Poor and Snowball (2010) found heritage positively impacted decisions surrounding student university choice. Many students were found to actively favour a university that demonstrated the presence of a strong legacy through the presence of heritage aged infrastructure and artifacts across a campus. Some students however felt isolated by the connection held by the university to its heritage which contained colonial overtones that were 'historically white or predominately of European descent' (Poor & Snowball 2010, p. 153). Colonial-style architecture can be perceived as a symbol of discrimination and a threat to racial or social minorities (Morey et al. 2002). While a university with a significant and visual cultural history has the capacity to imply prestige and deeply held values to one individual, it may communicate elitist beginnings and oppression to others (Cheng 2004). Such evidence provides additional insight into student connectedness and identity development, and further supports the notion that cultural built heritage contains strong symbolic dimensions and emotional expressions that engage at wider social levels. Implications suggest branding and marketing teams should careflully consider the use of heritage when attemtping to attract 'students from more diverse backgrounds' (Poor & Snowball 2010, p. 153).

Wider implications from this research may suggest that colonial infrastructure, iconic statues, and other significant heritage located across the RPA campus may generate feelings of oppression of exclusion amongst some organisational members. RPA was built as a monument to celebrate the

survival and recovery of Prince Alfred, and to care for people of all classes. The very nature of its grandiose Victorian structure may lie in juxtaposition to its central goal of providing health care to all regardless of class, creed, religion, or country. Furthermore, the imposing 1.5-metre white marble King George V statue, which stands atop a 1.5-metre white pedestal centrally located on the path the leads to the King George V building, may hold significant symbolic implications as a tool for collective memory to organisational stakeholders. This collective memory may present as both burdens and benefits to the organisation. Alternately, in some instances, colonial heritage is not perceived as offensive at all, as intended meaning is unknown to stakeholders or 'has been reinterpreted overtime' (Marschall 2016, p. 350). Marschall (2016, p. 351) suggests that 'colonial buildings, even if clearly associated with oppressive memories … tend to constitute too valuable an asset to be dismantled' and that provided they are structurally sound, are often modified to suit new purposes.

Heritage buildings have been demonstrated to contribute an 'important part of the cultural capital of urban heritage areas' (Lawton et al. 2021, p. 1). Built heritage and historic environments are strategic resources that can be utilised to increase the levels of skilled capital within a given area (Backman & Nilsson 2018). Implications from this suggest that institutions like RPA with long complex histories and material heritage may leverage heritage and history to attract a higher skilled workforce.

Heritage and history have also been used to invent traditions and create past narratives that support a fictionalised collective memory and identity. Hobsbawm (2012, p. 1) defines 'invented tradition' set of practices, normally governed by overtly or tacitly accepted rules and of a ritual or symbolic nature, which seek to inculcate certain values and norms of behaviour by repetition, which automatically implies continuity with the past'. Invented traditions are present amongst corporations in the form of invented heritage. Invented heritage is when an organisation 'invents traditions and creates non-existing' or mythical links to a fictionalised past (Brunninge & Hartmann 2019, p. 231), to construct an appearance of authenticity and brand legitimacy. This mythical or implied heritage presents an aura of reality and romanticised past (Hudson & Balmer 2013), that may contain an aura of authenticity that is subjectively perceived as genuine (Brunninge & Hartmann 2019). This invented past can manipulate and 'mask a corporation's present identity problems' (Brunninge & Hartmann 2019, p. 231), and in effect, contrives the present and future preceding the past, and in the case of invented corporate heritage, heritage is constructed entirely in the present' (Brunninge & Hartmann 2019, p. 23).

As symbols and actors, organisational artifacts such as the RPA entrance have expressive and instrumental roles to play in organisational sensemaking and sensegiving (Cappetta & Gioia 2006), and underpin organisational authenticity and legitimacy. Cappetta and Gioia (2006) argue that significance attributed to organisational artifacts shape internal and external images, that in turn affect the sensemaking/sensegiving processes that influence organisational identity. Member significance also affects 'the subsequent revision of the artifacts that represent that identity' (Cappetta & Gioia 2006, p. 3). The stately example of the RPA entrance communicates information about the organisation's technology, ideology, values, assumptions, rituals, myths and ways of doing things that constitute the framework for which members interpret meaning and find place (Ott 1989; Pettigrew 1979).

Stakeholder sensemaking of key organisational artifacts can also be guided by emotion, and that this emotion can ultimately be directed towards the organisation as a whole (Rafaeli & Vilnai-Yavetz 2004a; 2005). Research by Rafaeli & Vilnai-Yavetz (2004a, p. 671) revealed that artifact sensemaking involves 'emotion in interpretations that consider three dimensions of the artifact—instrumentality, aesthetics, and symbolism'. Instrumentality is defined as being associated with the tasks an artifact helps accomplish. Instrumentality is high if the presence of an artifact increases the likelihood of successfully achieving a task, and low if it diminishes the probability. In other words, artifact instrumentality is 'the extent to which … [an artifact] affects efficiency and productivity' (Vilnai-Yavetz & Rafaeli 2011, p. 7). The aesthetic experience is the sensory reaction to an artifact and is connected to organisational goals but separate from instrumental value. Vilnai-Yavetz and Rafaeli (2005) use the example of a black chair as aesthetically pleasing in a senior managers office, but unattractive in a flower shop. Yet the black chair serves an instrumental purpose in both environments.

Symbolism, the third dimension, is described as the associations generated by the artifact (Vilnai-Yavetz & Rafaeli 2011, p. 364). Numerous symbols are present across RPA ranging from single statues and artworks to larger organisational spaces, to entire buildings which all offer strong connections to the myths and sagas connected to the organisation. As such, these artifacts are multidimensional and must be taken into consideration before change is made within an organisation as the physical aspects influence 'behaviours, attitudes and emotion of employees' (Rafaeli & Vilnai-Yavetz 2004b, p. 92). Changing these tables or chairs may alter or break the concrete bond established that connects the organisational member to the organisation.

Not all material symbols however have the same 'concreteness' as some can be perceived by more than one sense (Gagliardi 2017c, p. 3). Gagliardi (2017c) notes that a framed image is experienced by only one sense as opposed to a space which is experienced through multiple senses. Such diversity of experience suggests a material setting offers hierarchies of significance, and that the type of artifact impacts differently across wider organisational dimensions. For example, it impacts differently on the 'processes (e.g., communication and developing corporate identity) in organisations, the ways in which artifacts can help us to understand cultural issues, the connection between artifacts and control, and the use of a deconstructive approach to explore theory and artifact' (Siehl 1992, p. 619). In the same way that past societies and civilisations are to varied extents characterised by their buildings and monuments, corporations and organisations – 'which can be seen as micro-societies' – build, structure and inhabit buildings and spaces that conform with their identity (Berg & Kreimer 2017, p. 49).

Buildings which reflect the purpose of an organisation, and that encourage inter relationships, are also significant elements of corporate strategy (Seiler 1984). Corporate strategy includes the use of artifacts as organisational control mechanisms and as agents for change and innovation. Cultural artifacts have been found to not only 'affect the formation of strategy, but also the execution of strategy' (Higgins & McAllaster 2004, p. 67). Witkins (2017) also views artifacts as a part of the organisational strategy, and as an organisational tool for control imposing aesthetic discipline on members. This occurs via a collection of expectations and constraints ranging from dress and modes of communication to building design, styling and space. Organisations design settings for member action 'through a certain presence, a structured tension, a readiness for action and a preparedness for experience which corresponds to the sensuous values manifested in the design of the situation' (Witkin 2017, p. 328). Artifacts as a result can be viewed as adornments for styling purposes that engage with a single emotional sense, and that serve a technical function and image development tool. Consequently, Witkin (2017) argues that material artifacts are integral to the design of a given situation in that they frame the appropriate member attitudes and responses. They guide situation design which frames the sociocultural context of action, and ultimately how the situation is to be lived by the organisational member. In other words, artifacts as symbols are both material tools and social tools that can guide and affect social engagement in pursuit of organisational outcomes (Rafaeli & Pratt 2013b).

Rafaela and Pratt (2013a, p. 2) attempt to shift focus from artifacts as 'mere' symbols to engage scholarship toward a deeper conversation and exploration of the 'subtleties and complexities of artifacts in enacting legitimacy, branding and identity, and as vessels for knowledge transfer'. Artifacts act as organisational knowledge sharing devices in that they can communicate multiple types of identity messages (Cappetta & Gioia 2006, p. 2). They can affect organisational member engagement by creating boundaries 'within organisational and knowledge sharing communities' (Rafaeli & Pratt 2013c, p. 4) and as linguistic artifacts, they are at the heart of communal understanding and interaction.

Research and literature that contextualises heritage as a branding and communications marketing tool is new and limited in scope, and is grounded in the private sector (Sacco & Conz 2023). Cultural history and heritage is primarily explored as a part of corporate brand identity as a tool to strengthen the brand-consumer relationship (see Balmer & Burghausen 2015c, 2019; Hudson & Balmer 2013; Urde et al. 2007; Wiedmann et al. 2011), and as a strategic asset to leverage consumer interest in authenticity, trust, uniqueness and brand differentiation (see Napoli et al. 2014; Riviezzo et al. 2021; Urde et al. 2007). Conceptions of heritage branding in the public sector are evident in the heritage tourism sector (see Balmer & Chen 2017; Fernández & Meethan 2014; Gumede & Ezeuduji 2021) and in the city and place branding literature (see Cvijić & Guzijan 2013; Pecot & Barnier 2015; Zhu 2018). Research into the use of heritage as a branding strategy across public sector buildings is limited to public universities as a marketing tool and point of difference for competitive advantage (Bulotaite 2003; Merchant et al. 2015; Panda et al. 2019; Rose et al. 2017).

Brand heritage is an element of brand identity that emerges from five core dimensions that have been termed 'the corporate heritage quotient' (2007, p. 7). These dimensions are: 'track record, longevity, core values, use of symbols and … an organisational belief that its history is important'. Heritage, when viewed as a component of organisational capital is central to an organisation differentiating itself within a given market. Organisational capital is the accumulation and combination of organisational capabilities and resources along with the organisational policies, structure, processes and behaviour (Lev & Radhakrishnan 2003). Organisational capital 'enables tangible and intangible resources such as machines, patents, brands and human capital to be productive' (Lev et al. 2016, p. 4). Like universities, hospitals seek to express their identity and uniqueness through branding and marketing (Wæraas 2008). Public hospitals still exist in a competitive environment in pursuit of funding, enhanced reputation and a competitive edge (Esposito 2017; Whelan et al. 2010). Therefore, determining the value of heritage as capital is key to

understanding the significance and usefulness of RPA heritage to the organisation. Sacco and Conz (2023, p. 20) however argue that despite the increasing acknowledgment of the value of heritage and its potential advantage, there is limited understanding in 'how companies design and project the communication of their corporate heritage to deliver customers unique selling propositions and to strengthen the emotional and symbolic ties between consumer and brand'.

Collecting, Corporate Heritage Collections and RPA Hospital

The act of collecting is a 'self-aware process of creating a set of objects conceived to be meaningful as a group' (Macdonald 2011, p. 82), 'and in the West, where time is generally thought to be linear and irreversible – implies a rescue of phenomena from inevitable historical decay or loss' (Clifford 1988, p. 231). Collecting is therefore an expression of value, and as this thesis aims to explore the value of RPA heritage to the organisation and to organisational members, is germane to navigating deeper, underlying drivers that construct values, or support the emergence of values surrounding heritage.

Collecting is a complex phenomenon yet to be fully understood as 'no comprehensive integrated model of collecting exists in the social science literature' (Belk 2012, p. 324). Belk (2013, p. 67) defines collecting as 'the process of actively, selectively and passionately acquiring and possessing things removed from ordinary use and perceived as a part of a set of non-identical objects or experiences'. Collecting is a distinct type of consumption activity consisting of at least three dimensions: conscious/unconscious, vertical/horizontal and structured/unstructured (Belk 2012, p. 552). The behaviour of collecting itself is 'difficult to define, but clearly the gathering together of chosen objects for purposes regarded as special is of great importance, as a social phenomenon, as a focus of personal emotion and as an economic force' (Pearce 2013). Formanek (2012) suggests up to a third of collecting motivations pertain to 'self', with the remainder related to acts of preservation, for restoration, for historic purposes, as a sense of continuity, as a financial investment and as an addiction. Duroust (1932, cited in Belk 2012, p. 317) contends however that 'objects or ideas in a collection must be valued for more than their utilitarian or even their aesthetic qualities'. While they may possess a 'utilitarian or aesthetic appeal', a collected object must ultimately provide 'additional significance to the collector due to [its] importance in contributing to the set of items that comprise the collection' (Duroust 1932, cited in Belk 2012, p. 317). Belk's further contends that collections are extensions of self, and that collecting serves as a legitimisation process where objects are transformed from a mundane commodity status into sacred icons. This conversion, accomplished by the 'bringing together' under the rubric of collection, was often 'sacralised' by being connected with

a prominent person (Belk 2012). In other words, in some instances, an artifact gains significance by having once been owned by a person of historical significance, or in having been a part of a collection once owned by a prominent figure.

Formanek (2012, p. 330) further suggests that 'if acquiring things aids our maintaining the continuity and cohesiveness of the self, their loss is bound to have adverse effects'. According to James (1984, p. 161), people feel 'personally annihilated if a life-long construction of their hands or brains—say an entomological collection or an extensive work on a manuscript—were suddenly swept away'. Such a loss leads to 'shrinkage of our personality, a partial conversion of ourselves to nothingness' (James 1984, p. 161). Collecting then can underpins identity at the individual level and the larger socio-cultural level.

Collecting types are many and varied with McDonald (2011) noting numerous distinctions existing in the extant literature. Distinctions identified differ between the 'taxonomic and the aesthetic, the clinical and the passionate, the systematic and the eclectic, the authentic and the inauthentic, the planned and the impulsive, the connoisseurial and the fetishistic, the high and popular cultural, the dealer and the true collector, and the institutional and the individual' (Macdonald 2011, p. 83). Why heritage is collected, preserved, presented or engaged with varies from institution to institution, however it is commonly agreed that heritage is used by both government and non-government organisations as a source and resource with production values (Cerquetti et al. 2023; Starr 2010). Further to this, the drivers behind institutional collecting, and the individual collecting within an institution, across these bodies both converge and diverge.

Collection drivers within organisations like RPA Hospital are two-fold. Firstly, they are an output of policies and procedures related to business administration and record keeping, meaning it is best practice and/or legislated to collect and store organisational records (see State Records NSW 2023). Secondly, collecting and collections are individual uncontrolled acts of protection and preservation framed within heritage derived notions of significance and value. Objects are collected and preserved by organisational stakeholders or members of the public when identified as containing heritage values. Policy documents, medical records, and general departmental administrative records that were once considered mundane and habitus are by virtue of space and time also perceived as significant receiving heritage status.

Corporate heritage and the corporate museum however occupies ‘a particular position, at the intersection of the cultural realm of public museums and the world of business, and is characterised by a managerial vision’ (Bonti 2014, p. 141). Organisations and companies showcase their ‘histories and interests’ via corporate museums, pursuing ‘cultural, social, and economic performance goals similar to traditional museums, but also ‘seek high organisational performance’ due to their connection with their parent company’ (Carloni et al. 2023). Heritage and organisational history is leveraged to offer a ‘source of competitive advantage’ (Sacco & Conz 2023, p. 19).

Cerquetti et al. (2023, p. 67) contend that in a ‘globalised world, where consumers appreciate authenticity, corporate museums and corporate archives are essential tools for counteracting invented heritage strategies’. Further to this, that collecting, preserving and presenting material and non-material heritage ‘can prevent and contain the risk of invented pasts’ through reinterpretation or idealisation (Cerquetti et al. 2023, p. 67). Heritage has in the past been used by corporations to generate a largely or completely romanticised mythical past to ‘generate an aura of authenticity to mask identity problems (Hudson & Balmer 2013). Beverland (2009, p. 145) suggests authenticity is achieved by building links to community through five strategies;

1. By embedding themselves within images of national culture reflecting traditions and stereotypes.
2. By constructing links to place of origin, often using material and non-material symbols
3. By embedding themselves within their industry to identify the important role played in the creation, growth and survival of an industry.
4. By embedding themselves in cultures, often coopting cultural myths and stories
5. By connecting to sub-cultural spaces by being active and sincere members of subcultures.

The generation of authenticity is key to the creation of an aura that underpins the corporate values, and by extension, the corporations existence (Beverland 2009; Brunninge & Hartmann 2019). This has been articulated as ‘brand ontology (brand nature), brand axiology (brand value grid) and brand epistemology (brand promise)’ by Hartemann and Ostberg (2013, p. 891). Through this, the journey and trajectory of the corporation – ‘where it comes from and where it is now relevant to its own

past', can be used to 'create and communicate' a richer story by an organisation for communication to the market (Brunninge & Hartmann 2019, p. 231).

Government organisations like RPA pursue similar communication strategies through corporate and clinical support units, strategic communications teams, and media units, all attempting to manage and control the internal and external image, identity, culture and certainly brand of the Hospital. This occurs through electrical distributed memos, strategic plans, media releases, social media platforms and websites, and through physical engagement strategies like staff BBQ's and Symposiums (see Sydney Local Health District 2019a; Sydney Local Health District 2023c).

Government Social Obligations and Corporate Social Responsibilities

At a time of increased organisational and corporate transparency, and significant changes in corporate social responsibilities and environmental, social, and governance standards, government bodies and private enterprise need to justify their expenditure and behaviours in all operational areas (Jamali et al. 2010). Heritage management institutions and organisations are also under increasing financial pressure to 'document and communicate the economic and social benefits of cultural heritage' (Labrador & Silberman 2018, p. 5). Complexities surrounding resource allocation mean many organisations with cultural heritage compete for resources alongside other social goals (Navrud & Ready 2002). As previously demonstrated, many corporate and government organisations collect and preserve cultural heritage, allocating resources towards preserving and managing movable collections and built heritage. Effective heritage management requires the provision of space for storage and display, the development of professional support staff and the construction of appropriate facilities suited to ongoing preservation. The diversion of organisational resources to meet these needs highlights complex issues regarding value verses cost. These issues are often driven by several factors, that sometimes act as barriers, which include funding limitations, particularly with built heritage, current and future space restrictions for movable heritage, policy directives, ethnic or social discrimination, and as a result of managerial vision and understanding (Bonti 2014; Wang et al. 2021). Organisations value floor space by the square metre (Naor et al. 2022), and work force by the hour (Ryder 2018), therefore management will often focus on the financial gain offered by every organisational decision. Any failure in knowledge and understanding concerning the meaning and value of heritage prevents the future development and effective use of heritage by an organisation (Calvo-Iglesias et al. 2006; Wang et al. 2018). Management therefore seeks to understand how every component within the organisation adds value, supports the organisational primary purpose and underpins core business goals.

Heritage, Hospitals and Resources

Health care facilities such as RPA face a myriad of new and increasing funding and operational challenges as a result of aging infrastructure, climate change, an aging population and global pandemics (Armstrong et al. 2007; van Gaans & Dent 2018). Maintaining built and architectural heritage is costly and, in many circumstances, not practical. Many heritage buildings are not adequately suited to modern organisational requirements or practices, and as healthcare facilities require specialised clinical spaces, the continued use of heritage built environments poses numerous issues surrounding patient and staff comfort in relation to physical design (see Eijkelenboom & Bluyssen 2022; Salonen et al. 2013; Tyson et al. 2002; Ulrich et al. 2008). RPA Capital Infrastructure and Engineering staff have noted that many spaces at RPA are simply not suited to modern healthcare (J Gowdy 2021, personal communication, 21 March). Refurbishments require extensive individually tailored strategies and costly upgrades (Filippi 2015), and the 'level of complexity [surrounding renovations] increases with the age of the buildings' (Sheth et al. 2010). New medical discoveries require constant changes to infrastructure, and relocations to new buildings often result in a failure to regenerate old ones leading to their progressive degeneration (Gola et al. 2022, p. 1). Furthermore, green-retrofitting heritage buildings to increase energy efficiency and minimise built infrastructure carbon footprints is 'often more resource and energy intensive than the renovation of conventional buildings' (Nair et al. 2022, p. 13), therefore knockdown-rebuild strategies often make more financial sense.

Healthcare resources are also increasingly strained by the direct effects of climate change as global warming brings disasters including floods, droughts, fires and heatwaves (Bose-O'Reilly et al. 2021; Guihenneuc et al. 2022). These issues impact healthcare services as resources are diverted away from front line care towards developing resilient healthcare facilities and services that can adapt to and mitigate the effects of climate change related events (see Lo et al. 2017; Noji 2000; Waring & Brown 2005). The indirect effects of climate change also pose significant challenges to healthcare services as populations at risk will suffer greater consequences (see Akerlof et al. 2015; Davis et al. 2010; Jones et al. 2020) and the population as a whole require increased medical intervention and support (Romanello et al. 2021). Infectious disease pandemics like COVID-19 have further pressured health care services as additional or retro-fitted facilities are required to treat the increased influx of patients due to the immediate effects of the disease, or due to ongoing effects of significant social disruption (Elbogen et al. 2021; Roy et al. 2021).

Organisational Heritage Management

The protection and preservation of cultural heritage in Australia is supported by numerous instruments at both Commonwealth and State levels. Several instruments exist including the *Natural Heritage Trust of Australia Act 1997*, the *Protection of Movable Cultural Heritage Act 1986*, and the *Australian Best Practice Guide to Collecting Cultural Material 2014*. In NSW the Heritage Act of 1977 with 2010 amendments requires government agencies to compile a register of heritage assets for protection on behalf of the community, identifying that they 'form an important part of our [Australian] identity' (Office for the Arts 2021).

Collecting and preserving cultural heritage in NSW assumes new meaning and relevance when framed within organisational settings. Neither government nor private sector organisations are legally mandated to identify, collect and preserve organisational cultural heritage that falls beyond the scope of the *NSW Heritage Act*. Government organisational responsibilities surrounding cultural heritage are underpinned by policies, strategic frameworks, codes of conduct and management guidelines that 'give guidance to decision-makers and custodians of our heritage places' (Department of Planning 2021). Exploring and analysing the efficacy of public sector governance instruments is beyond the scope of this thesis, however understanding and acknowledging their intent within an organisation is important when exploring the nature of organisational governance mechanisms and the protection and preservation of heritage by organisational stakeholders.

Public policies are key instruments used by public sector organisations which act as formal authoritative statements of intent that regulate, direct and guide decisions towards achieving rational outcomes (Althaus et al. 2022). The core purpose of policy is to communicate and influence organisational values, philosophies and culture and make transparent what stakeholders can expect from the organisation, and what the organisation seeks to gain from stakeholders (Cairney 2019) . Policy also reflects what the organisation believes to be its organisational and wider social responsibilities. Klimczuk (2015, p. 580) notes that good public policy 'takes into account reconciliation of conflicting interests of individuals, groups, and organisations and is based on agreed values which then influence the objectives, principles, and styles of policy implementation'.

Expectations surrounding organisational behaviour can also be viewed through the lens of corporate social responsibility (CSR) and environmental social governance (ESG). Organisational policies and strategic plans are frequently developed in combination with CSR's and ESG's. CSR, also known as corporate citizenship and corporate sustainability, are key terms used to describe the social and

environmental contributions and consequences of corporate activity, and are chiefly concerned with the relationships between governments, corporations and individuals (Crowther & Aras 2008; Jenkins & Yakovleva 2006). ESG's are extensions of CSR's which elevate environmental protection and sustainable development as a social responsibility, but also seek to produce quantifiable data and results towards financial reporting (Dathe et al. 2022).

Good corporate citizenship through effective CSR design and implementation will see a well-managed corporate–community relationship develop which can minimise negative social and environmental impacts, and maximise positive ones (Marsden & Andriof 1998). Importantly, it can ensure the continuance of organisational legitimacy and a social license to operate (Sarker 2013). Legitimacy, the perceived need to gain acceptance, leads organisations to strive for compliance, and in some circumstances, provides motivation to go beyond compliance (Clegg et al. 2015; Sarker 2013). Responsible management through effective CSR also provides some measure of brand and image insurance. Through the integration of stakeholder perspectives management can maximise positively reinforced brand imagery and, ideally, optimise returns (Werther & Chandler 2005).

While CSR's and ESG's are traditionally grounded in the private sector, public sector organisations like hospitals are facing mounting pressure to demonstrate governance strategies that extend beyond core business frameworks, and to include wider social responsibilities regarding the impact of their operations (Uyar et al. 2021). Organisational stakeholders look for contributions and behaviours that extend beyond positive financial performance and expect 'triple bottom-line reporting – reporting on People-Planet-Profit' (Clegg et al. 2015, p. 405).

Within government settings such as the NSW Ministry of Health, government policies, strategic plans and codes of conduct which together guide organisational behaviour also assist with the continuance and development of organisational legitimacy. Hospitals strive for legitimacy on several fronts including in their quality of health care, research, innovation and financial management. Legitimacy can be differentiated into three different approaches: pragmatic, cognitive and moral. Pragmatic legitimacy relies on an organisation's ability to control its environment, including stakeholders, viewing legitimacy as a manageable resource (Ashforth & Gibbs 1990). Cognitive legitimacy sees the environment control the organisation. The organisation aligns its actions and directives with that of societal expectations (Basu & Palazzo 2008; Suchman 1995). Legitimisation occurs through adapting and evolving in response to external driving factors (Basu & Palazzo 2008). Adaptations include voluntary codes of conduct, voluntary initiatives, best practice guides and non-

regulatory agreements (ACCC 2021). The use of such instruments are often attempts at demonstrating self-regulation to establish or maintain legitimacy (Sarker & Gotzmann 2009; Sarker 2013). Moral legitimacy, the final approach, sees organisations pursue legitimacy by co-creating normative behaviour through a collaborative approach to stakeholder engagement (Suchman 1995).

Government departments such as the SLHD utilise policies and guidelines to assist in the management of the organisation. Compliance is mandatory regarding policy and procedural documents but adherence to guidelines is not. Hospitals are producing voluntary codes of conduct and public positioning documents such as Planetary Health Frameworks (see Northern Sydney Local Health District 2021) and the SLHD Environmental Health and Sustainability Plan: 2023-2026 (in draft) that demonstrate a commitment to sustainable development goals. The museum and archives collection is governed by the 'Museum and Archives Collection guideline: RPAH_GL2018_007'. Through these documents they demonstrate to stakeholders effective management strategies regarding initiatives and programs in healthcare and hospitals that extend beyond front line clinical health care.

Conclusion

The complexities that frame both cultural built heritage and movable heritage within an organisation, while numerous and diverse are additionally complex within a public service facility such as a large quaternary hospital like RPA. Public hospitals exist with the primary purpose and core business of providing healthcare to the community. In doing so they face ongoing resourcing issues and challenges that are increasing in the face of global pandemics, climate change and aging infrastructure. Hospitals are also recognising that effective healthcare constitutes not only front-line clinical care, but also the environment in which that care exists, and further, how it is engaged with by organisational stakeholders. Both built organisational heritage environments and movable heritage pose physical and financial challenges regarding their suitability and future viability, but also offer numerous as yet, unidentified socio-cultural values. The presence of heritage increases the complexities surrounding capital infrastructure and engineering, environmental health, staff health and wellbeing, and ultimately positive patient outcomes. Built heritage environments are engaged with daily by organisational members in that heritage listed hospital buildings are living heritage spaces either in use or readapted for use. Movable heritage exists within a different framing in that it is preserved and displayed or preserved and archived away from daily engagement. The value it offers is orientated differently in that it presents both use and non-use socio-cultural values, as it is both accessible and inaccessible to organisational stakeholders.

Movable and built heritage offer benefits and burdens to the organisation. In the case of RPA they are suggestive of a hospital with a long institutional history built on a wealth of knowledge and prestige. They are also suggestive of a facility having emerged from a colonial framework, developed and governed by a largely white male elite tier of society across space and time. Sensemaking of these benefits and burdens occurs through emotional dimensions involving instrumentality, aesthetics and symbolism, and as organisational knowledge-sharing devices, can communicate multiple identity messages to organisational and community members, and constitute an important component of organisational dynamics. The strategic use of heritage by management for stakeholder benefit and organisational image and cultural development is evident at RPA. How hospital heritage is then perceived, engaged with, and valued by organisational and community stakeholders offers further valuable insight which could be operationalised within the organisation to further strategic effect.

Current research into heritage within corporate settings is limited to exploring heritage for brand extension, organisational legitimacy and as a tool to leverage brand differentiation. While there is value exploring these conceptions within a public hospital, they are limited to representations of image aimed to develop and manage perceptions external to the organisation. How heritage affects organisational staff and volunteer member stakeholder perceptions, culture and identity are poorly understood within the heritage, organisational theory, or hospital management literature. The recent global pandemic has highlighted the complex nature and interrelationship of current events where history and heritage are both unfolding as product and process. How this is understood, valued and used within a large public hospital is fundamental to current and future organisational heritage management strategies.

The next chapter, Chapter 4, will outline the study methods and methodology utilised including the data collection, data analysis and coding strategy. This thesis utilises a variation of grounded theory methodology. Pre-existing frameworks of understanding such as the various socio-cultural values of heritage, Schein's three layers of culture, and Albert and Whetton's CED dimensions of identity will be applied to the emergent themes and codes.

Chapter Four: Research Design – Methodology and Methods

Introduction

This study explores material heritage within a hospital environment, which is a unique setting and organisational case study or this type of research. According to Yin (2017, p. 18) a case study is 'an empirical inquiry that investigates a contemporary phenomenon within its real-life context'. The goal of any case study analysis should be to focus attention on 'the uniqueness of the case and to develop a deep understanding of its complexity' (Bell et al. 2018, p. 61), whilst remaining connected to the discourse outlined in the literature review. Through the presentation of a range of material organisational artifacts, perceptions of use and value are explored.

The previous chapter outlined the history and heritage of RPA from foundation to present. This chapter explains the research methodology including the methods utilised in the planning, preparation, and collection of data. While not strictly adhering to the principles of Grounded Theory Methodology, various Grounded Theory principles were utilised during data collection and analysis. The chapter also discusses how data were analysed using NVivo-12, and the coding strategy applied.

Methodology

A Qualitative Study

As this research study investigates the non-economic value of material cultural heritage at RPA, and organisational member perceptions of value, interviews and focus groups were considered the most appropriate instruments for revealing organisational member thoughts and beliefs. Therefore, an inductive exploratory qualitative research strategy was considered more appropriate over a quantitative method. Inductive methods of research require a researcher to gather data relevant to the topic explored, analyse the data to expose patterns or themes, and develop a theory.

Qualitative strategies that include interviews and focus groups utilise the collection of data in natural settings 'sensitive to the people and places under study, and data analysis that is both inductive and deductive' to establish patterns and themes (Creswell 2013, p. 44). Such modes of investigation 'aim to control meaning through language … providing space for respondents to communicate their feelings, thoughts, values, experiences and observations in such a way … that renders their

inner worlds accessible' (Alvesson & Karreman 2011, p. 31). Further benefits of qualitative research reside in the direct contact and communication had with respondents in their homes or workplaces which provides a more complex detailed understanding of the issue being researched (Creswell & Poth 2018). Silverman (2007, p. 85) further adds 'it can address the "whats" and "hows", and any other underlying social processes that might be occurring in any given context … by studying the local management by participants of sequences of interaction which are themselves organisationally embedded'.

When using interview and focus group data to generate theory where no previous theory exists, Urquhart (2013) argues that grounded theory is an ideal research approach. Within grounded theory an interpretive definition of theory emphasises understanding rather than explanation (Charmaz 2014).

The Principles of Grounded Theory

Grounded theory is a qualitative research methodology concerned with exploring behaviour and interactions, and aims to gain insights into experiences (Goulding & Saren 2010, p. 70). This methodology offers flexible yet systematic inductive methods for data collection and analysis aimed towards theory development 'explicitly from the study of cases' (Savin-Baden & Major 2013, p. 182). Theories developed are considered 'grounded in empirical data generated from the field' (Charmaz 2014, p. 168). In other words, the researcher grounds a 'theory in the views of the participants' (Creswell & Poth 2018, p. 67), that 'is derived from the data and cannot be divorced from the process by which it is developed' (Glaser & Strauss 2017, p. 5). Theory development occurs after the collection and analysis of data, and not through the application of predeveloped theoretical frameworks.

There are several variations of grounded theory, and 'what is and what is not grounded theory is hotly contested' (Savin-Baden & Major 2013, p. 183). Glasser and Holton (2004, p. 3) suggest that classic grounded theory is a 'set of integrated conceptual hypotheses systematically generated to produce an inductive theory about a substantive area'. This research study departs from classic and later modified versions of grounded theory in two significant ways. Firstly, undertaking literature reviews prior to data collection is considered contentious by grounded theory practitioners as predetermined knowledge and concepts may influence the researcher (Strang 2015). Suddaby (2006, p. 635) rejects this notion arguing the original conception of grounded theory developed by

Glasser and Strauss linked 'substantive theory, or theory grounded in extant research in a particular subject area' to grounded theory.

> Substantive theory is a strategic link in the formulation and generation of grounded formal theory. We believe that although formal theory can be generated directly from data, it is more desirable, and usually necessary, to start the formal theory from a substantive one (Glasser & Strauss 1967, p. 79).

Suddaby (2006, p. 635) further adds that 'formulation of grounded theory was never intended to encourage research that ignored existing empirical knowledge'.

The second deviation from traditional conceptions of grounded theory is that a specific research question is explored in this study, instead of being 'guided by a grand tour question' (Mitchell 2014, p. 2). Grounded theory requires no research question, but more an unexplored field in search of an answer. Through exploring and discovering social processes, that answer is the generation of theory where previously there was none. Suddaby (2006, p. 634) however strongly contests this suggesting 'the idea that reasonable research can be conducted without a clear research question and absent theory simply defies logic' as does 'the ability to disregard one's prior knowledge and experience'.

Consequently, several tenets of grounded theory were absorbed into the methodological process and applied during the collection and analysis of data. Principles applied were derived from the model proposed by Corbin and Strauss, which is philosophically underpinned by an interpretivist paradigm (see Figure 27). The interpretivist approach to research takes an ontological position of relativism, which is the view that reality is subjective and differs from one individual to the next. Levers (2013, p. 2) 'states the purpose of science from a relativist ontology is to understand the subjective experience of reality and multiple truths'. Reality from a relativist perspective is not distinguishable from the subjective experience of it (Lincoln & Guba 2011). Reality emerges when 'consciousness engages with objects that are already loaded with meaning' (Crotty 1998, p. 43). Concepts such as truth and reality are both relative to and understood within a broader social framework. In other words, reality is thought of as multiple constructions undertaken by organisational members according to their own world views at a given moment in time and space. Knowledge then emerges as a result of the interaction with that environment and through the passage of experience, and reality is built based on these individual experiences.

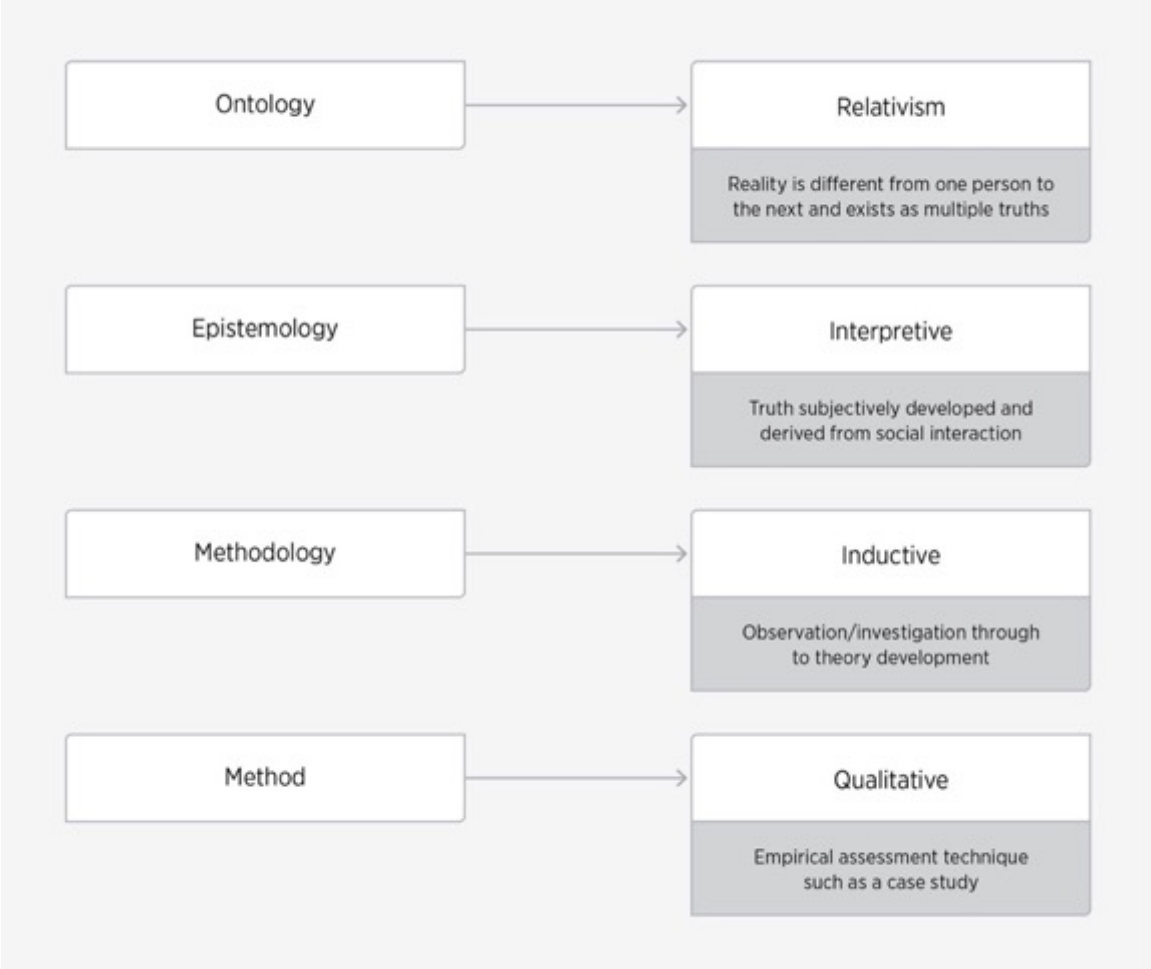


Figure 27 Research Strategy

Within an interpretive paradigm, epistemology is one of subjectivism, meaning reality is subjective and socially constructed. According to Crotty (1998, p. 3) epistemology is a 'way of understanding and explaining how I know what I know' and explores the relationship between knower and knowledge. Subjectivism posits that 'data collected are a subjective perspective of the participant view and must include the perspectives and voice of the people studied' (Strauss and Corbin, 1992; p 279). This view extends to the researcher's personal perspective. The researcher experiences some degree of bias due to the interrelationships that exist during the data collection process, the insider view of the organisation and due to their own subjective interpretation of the data.

The decision to apply an interpretivist approach to this research project was twofold. On one hand it effectively captures the researcher's personal view of reality and existence and on the other, it supports their belief that study respondents can only share an interpreted view of reality. Interpretivism was as a result considered the most suited philosophy as it integrates human

complexity into the study. In this instance, hospital staff members actively or passively engage with organisational cultural heritage across the Hospital campus each time they attend work. Members therefore experience a process, action, inaction, interaction and response to organisational cultural heritage from which an explanation can be generated (Corbin & Strauss 2015; Savin-Baden & Major 2013). How respondents engage with and perceive cultural heritage may then be influenced by their subjective view and their position within the organisation. For example, a senior administration executive may perceive cultural heritage differently from a carpenter. One staff member may frame value relative to the daily pragmatics and core business of running a hospital while the other might perceive a larger organisational image and identity framework.

Although this research study is underpinned by an interpretivist philosophy, which is also reflexive, grounded theory as a research method contains several analytical steps. These steps 'consist of coding data; developing, checking, and integrating theoretical categories; and writing analytic narratives throughout inquiry' (Charmaz & Belgrave 2007). The reflexive nature of grounded theory demands constant comparison between emergent theory (codes and constructs) and new data, and where neither data nor theories are discovered, but are constructed to generate a core category and pattern of behaviour (see Corbin & Strauss 2015; Halaweh et al. 2008; Hallberg 2006; Richards & Morse 2012) (see Figure 28).

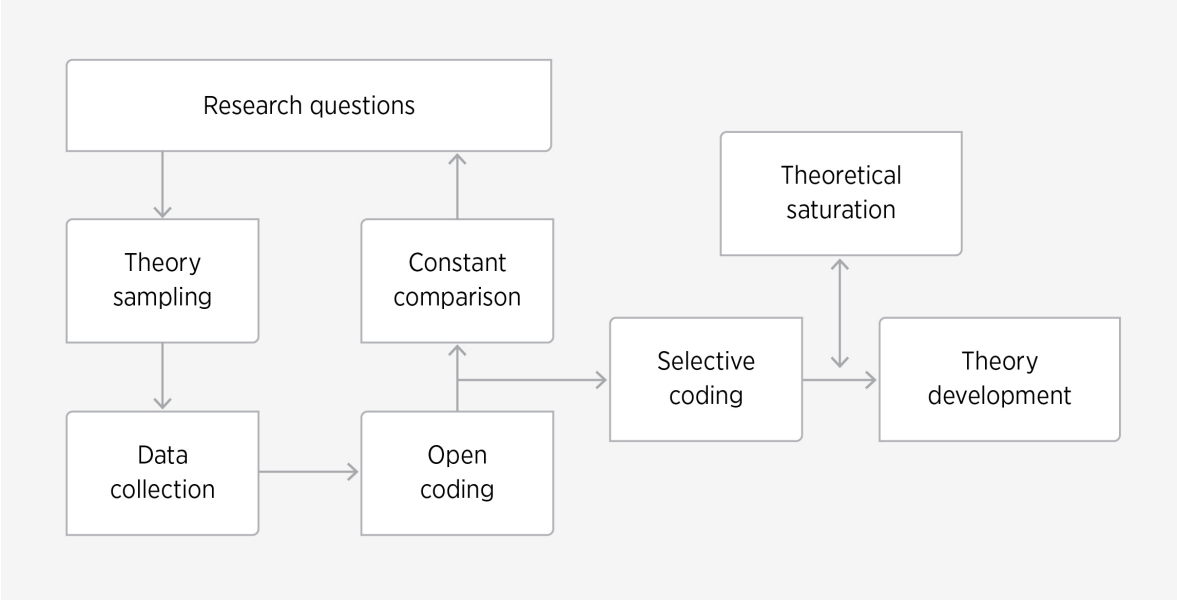


Figure 28 Grounded Theory Concept Levels (source: Author, based on Strauss and Corbin, 2008)

Data analysis begins with open coding where categories are created. Open coding involves line by line analysis, where key concepts and phrases are identified and sub-categorised or categorised through labelling with a term, often derived directly from the transcript and in the language of the respondent, called an in vivo term (Creswell & Creswell 2017). This step permits the researcher to begin conceptualising components within the data for reflection, understanding and preliminary theoretical development. The next stage, known as axial coding, identifies relationships and connections between the previously developed categories and sub-categories. During each coding process, data from each respondent is compared for similarities. The final stage, selective coding, occurs when clusters are generated around categories, and categories are methodologically related to one another to build clear relationships. Categories are then integrated together, theoretical frameworks built and a grounded theory developed (Urquhart 2013). This process continues until data saturation is recognised. This occurs once no new codes are identified and improvements to the theoretical model developed are minimal. Daengbuppha (2006, p. 384) states 'this is the stage where theoretical saturation is achieved and internal validity tested'.

In summary, principles of grounded theory were chosen to underpin the method and methodology of this qualitative research project for the following reasons:

1. Grounded theory is rooted in the reality of subjectivism.
2. Grounded theory aims to construct theories regarding complex social phenomena where there were previously none.
3. Grounded Theory permits the researcher to gain a 'richness of data from a range of perspectives (multiple realities) and emphasises a focus on meaning and interpretive understanding' (Daengbuppha et al. 2006, p. 370).
4. Grounded Theory requires the researcher to be immersed in the field and data, and as the principal researcher is directly employed in the field being studied, a deeper level of understanding will be gained regarding organisational member perspectives and values.
5. An analysis of interviews and focus group narratives by means of participant direct observation in naturalistic settings through an interpretivist lens provides for an appropriate theoretical sensitivity and fit.

Theoretical Sensitivity and Staying Open

A key tenet of grounded theory is the researcher's acquisition of theoretical sensitivity. Charmaz (2014, p. 135) says 'to gain theoretical sensitivity, we look at studied life from multiple vantage points, make comparisons, follow leads, and build on ideas'. In other words, during data gathering and analysis a researcher can discover relationships between their codes and categories that enable the development of theory that works with and is relevant to the field under study. What makes it 'sensitive' is that the researcher is steeped in the field of investigation and associated general ideas, and that hypothesis and concepts not only emerge from the data but are developed and interpreted in relation to the data during the research process (Glaser & Holton 2004). Glaser and Holton (2004, p. 11) add that 'the first step in gaining theoretical sensitivity is to enter the research setting with as few predetermined ideas as possible'. Martin and Turner (1986, p. 142) note, however, that 'preconceptions cannot, of course, be wholly abandoned, and we do not suggest that they should be'. Charmaz further supports this, quoting Dey (1999, p. 251) in that a 'researcher should approach their research with an open mind but not an empty head as researchers hold prior skills and knowledge that should not be discarded'.

Such notions take on new meaning in this study as it is not possible for the researcher to exclude pre-knowledge. The researcher of this thesis, employed as Sydney Local Health District as Director of Heritage and Environment, is embedded within the organisation under investigation and has built an extensive body of knowledge surrounding organisational member views of heritage. E.H. Carr (2018, p. 78) wrote that 'the historian is part of history' with a particular 'angle of vision over the past'. In the same way that a historian influences the history that they write, the researcher's roles as both museum manager and researcher may influence participant responses. Whilst theoretically it is possible to approach the research with a professional sense of openness, as discussed in the next section, the researcher is however firmly entrenched within the research process.

Strauss and Corbin (2015) suggest that other areas that assist in the development of theoretical sensitivity include a comprehensive understanding of the literature when coding and building categories, personal and professional experience, and through the analytic process itself. This ultimately leads to 'increased insight into the data and field being explored, leading to rich data and preventing the researcher from becoming overly immersed in the respondents world view that interpretation then becomes biased' (Charmaz 2014, p. 127).

The Researcher in the Study

Academically rigorous qualitative research requires a researcher to declare personal underlying assumptions and potential biases. Carr (2018, p. 22) argues that the facts of history never come to us 'pure', since they do not and cannot exist in a pure form; they are always refracted through the mind of the recorder. Contextualising this statement within this study, it is crucial for a researcher to be transparent regarding their relationship and role within a qualitative study to make their research credible. The relationship to the organisation under investigation and to the participants being investigated are influenced not only by the researcher's position, but also by their professional and life experiences.

As previously outlined, the principle researcher of this thesis is grounded in an interpretivist view; that is, they accept the influence of their values on and therefore dynamic relationship with the data, and they understand that their view of the world is generated through or guided by interactions with others (Greenbank 2003). Blair (2015, p. 14) suggests 'such a perspective addresses the concept of interpretation and subjectivity from the start and does not pretend to be purely *objective* or classically *scientific*'.

In clarifying their role, a researcher may position themselves as 'insider-researcher' or 'outsider-researcher'. An insider-researcher holds pre-existing knowledge, even an intimately engaged or deeply embedded relationship with the organisation they are studying, while an outsider-researcher doesn't belong to the group under investigation (Breen 2007). Bonner and Tolhurst (2002) identify three key advantages of being an insider or 'native' researcher: the capacity for a greater understanding of a group's culture; an ability to interact naturally with the group and its members; and a previously established relational intimacy with the group. The researcher may also hold increased knowledge regarding the politics of the organisation, hierarchical structure and unspoken organisational dynamics that can only be gained through prolonged exposure to organisational internal workings (Unluer 2012).

While there are various advantages to being an insider-researcher, it is critical to identify the possible disadvantages associated with this position. Key to this notion is the loss of objectivity and ability to effectively identify new concepts and theories in the data due to preconceived notions as a result of the researcher's level of daily immersion (DeLyser 2001; Hewitt-Taylor 2002). Bogdan and Biklen (2007) note that a researcher may find their organisational role in contradiction to that required of a researcher, which requires some level of investigative and analytical separation.

Brannick and Coghlan (2007, p. 72) contend that 'provided researchers, through a process of reflexivity, are aware of the strengths and limitations of their preunderstanding … they can use their experiential and theoretical knowledge to reframe their understanding of situations to which they are close'. This reframing can assist in developing a superior understanding regarding the actions and inactions that take place during the research process. According to Bryant (2009, p. 29) 'researching is not simply a case of collecting data or evidence, the researcher is a key factor in the research landscape, a link in the chain that reaches iteratively around data, codes, concepts and tentative theories'. Under these conditions, the researcher's prior experience is most certainly a source for bias or prejudice. Gibson and Hartman (2014, p. 24) explain that 'the distinction we are looking at here is the distinction between using preconceived notions and having preconceived notions'. As a result of the researcher's relationship to the Hospital and ontological position surrounding global cultural heritage, it is not possible to approach this study without preconceived notions. What matters is how they are applied to the study, and 'it is often precisely people's prejudices that enable them to produce innovative insights and alternative models and accounts' (Bryant 2009, p. 21).

As outlined in Chapter 1, the researcher had been employed for three years at RPA as Manager of Museum, Archives and Educational Facilities at the time of data collection. During this time, they attended numerous organisational meetings, built relationships with members from departments integral to the protection and preservation of cultural built heritage, and developed numerous relationships with long-serving staff members. Each of these aspects provided deep insight into organisational beliefs from both a strategic and pragmatic organisational position, and from an emotive and deeply personal member perspective. Such knowledge provided a significant grounding in the field under empirical investigation.

Before the study began, the researcher had over the years, numerous informal conversations with hospital staff regarding the perceived value of RPA's cultural heritage and organisational history. As a result, several participants in the study held a pre-existing relationship with the researcher. The researcher knew some participants in the study, having experienced daily or weekly contact during workplace activities. Other participants held a passing knowledge of the researcher's existence and role, while some had no prior relationship at all. Strategies considered to mitigate the impact of these conversations and relationships on the research and the researcher included the possible exclusion of colleagues working within the researcher's immediate sphere of operations, and/or the

replacement of the principle researcher in selected interviews and focus groups. After consideration these options were rejected due to past observational experience by the researcher. The Hospital was viewed as a challenging environment to recruit staff for participation in non-clinically oriented studies, and further the institutional knowledge and insider-research perspective of the researcher would prove beneficial during the research process.

Another source of possible bias regarding a pre-existing relationship with the researcher can be identified in Focus Group Two. In Focus Group Two, two participants were staff members who reported directly to the researcher. These staff members chose to participate as they felt they could contribute to the research having worked within and managed a heritage-listed building on the Hospital campus. Both employees held strong opinions and were free to communicate these opinions at any time regardless of the line management relationship. When these staff members disagreed with their manager, they would respectfully inform them without hesitation.

Participant Study Bias

The method of participant recruitment and the type of participant recruited saw a study bias emerge during this project. Bias can occur in several areas in research including during the planning, data collection, data analysis and publication phase of a project. Pannucci and Williams (2010, p. 1) argue that bias cannot be limited to such 'dichotomous variables' as 'is bias present or not'? They argue instead that 'reviewers of the literature must consider the degree to which bias was prevented by proper study design and implementation' (Pannucci & Wilkins 2010, p. 1). The SLHD Ethics application (discussed later in more depth) stipulated a passive approach to recruitment. A passive approach is a method bias as it limits a more diverse recruitment process and therefore risks restricting the range of views sourced. It can limit recruitment to those interested in the field of study, and who are willing to provide time for involvement. It also has the potential to exclude or at least limit dissenting opinions as members with dissenting views may avoid involvement in the study through either a lack of motivation or for fear of offending the principal researcher who is employed at the Hospital.

This method bias became apparent during the data collection phase when several respondents self-identified as people interested in the study and its aims. These respondents also self-identified as people who innately value cultural heritage and who take a general interest in history. This interest included global cultural heritage, domestic and local cultural heritage, and an interest in the history of the Hospital. Several respondents referenced overseas travels or discussed local cultural heritage

when building analogies during interview and focus group sessions. Such references demonstrate an inherent interest in and enjoyment of cultural heritage. Respondents also perceived non-use value in cultural heritage regardless of having seen or experienced it. In one instance Focus Group 2 Respondent 4 described study participants as a 'skewed demographic', who may be the antithesis of the wider organisation view. Interview Respondent 3 acknowledged that some people aren't interested in history and exhibited a curiosity regarding what value they saw in the Hospital cultural heritage. Interview Respondent 13 stated that they don't like seeing old things discarded or changed. They also demonstrated traits associated with the 'collector' phenomenon.

Another bias considered during the design phase of the research was the impact older and more senior organisational members might have on focus group sessions. A person's social and organisational status may influence social interactions within a group (Danescu-Niculescu-Mizil et al. 2012). Ayrton (2019, p. 324) argues that participants 'are implicated in positional relations of power which shape their interactions with each other and, in turn, how knowledge is discursively produced'. In other words, the inclusion of executive directors, general managers or even a manager and a subordinate in the same focus group session may alter the discussion due to the nature of power relations and presence of social power. Ayrton (2019, p. 324) suggests that 'interaction is not neutral: it is shaped by and revealing of the power relations that exist between group members'.

Ayrton (2019, p. 336) posits that 'during the course of focus group discussions, participants lay claim to power, surrender it, confer it on others, negotiate its bases, harness its dynamics to strengthen a rhetorical purpose, and reinforce or question its corporate experience'. All six bases of power could conceivably be exerted or experienced during focus group sessions. Legitimate power might impact on participant responses as the presence of an individual with known values surrounding RPA's heritage may alter or limit dissenting or supportive views. Expert and Informational power may alter engagement of participants who feel embarrassed or threatened when not having the level of articulation or knowledge necessary to adequately explain their thoughts and feelings around a concept or idea. Coercive, Reward or Referent power may present because of pre-existing professional relationships between staff members, including with the principal researcher. Ayton (2019, p. 336) suggests a more effective observation and understanding of power relations in focus groups can be achieved by an approach that decentralises power. This is achieved through flexible facilitation, recruitment based on commonality and more attention paid towards 'multiple, flexible positionalities of facilitators and how these are mobilised' (Ayrton 2019, p. 336).

The key to managing research bias is both mitigating it where possible with effective planning and management strategies and identifying it early. Identifying bias early enables the researcher to weave that bias effectively and openly into the project as a part of the narrative and to identify it as a research limitation. The self-selection bias created by participants will be documented within this thesis as a limitation, as active recruitment of organisational stakeholders was not permitted by the SLHD Ethics committee. This was the approved recruitment process without exception, and no other process could be pursued. Participant bias however was to some degree mitigated through the diversity of respondents involved in the study. Focus groups contained respondents with various organisational backgrounds, length of employment, range of roles within the organisation, organisational status, age, and socio-cultural views. Respondents were candid about both the issues faced with cultural heritage at the Hospital and the benefits and disadvantages experienced by its presence. This does not however mean that the study group was representative of the wider organisational body. As outlined in Chapter 3, large public hospitals like RPA consist of numerous professional and non-professional streams. It would take a much larger sample group to attempt to capture respondents from each area. The study body did however capture representatives from both clinical and non-clinical streams, as outlined later in the chapter.

Due to the nature of recruitment, limitations and restrictions on availability and time, recruitment based on commonality was not possible. A more passive flexible approach to facilitation, however, was adopted in that the researcher only intervened in the session when the discussion excessively strayed from the central themes being explored, or when one individual overly dominated the discussion. This was approach was favoured to ensure no agenda was asserted or limitations imposed by the researcher, thus ensuring discussions could pursue any course by study respondents.

A further study bias occurred due to one-on-one interviews being held in the researcher's office as opposed to a neutral meeting space. This occurred as no other small private quite space in the Hospital could be sourced that coincided with staff availability. This was an unavoidable limitation that may have resulted in study participants experiencing legitimate, coercive, or referential power as a result of the interview space.

Study Limitations and Strengths

All research has limitations and weaknesses (Creswell & Poth 2018). Critical evaluation is an essential requirement that ensures limitations and weaknesses are recognised and addressed early in the research process and are openly acknowledged later in the findings. Several issues were recognised

within this project. Key to these was the insider position of the researcher in which both advantages and disadvantages were identified. The researcher's identity and position as Manager of Museum, Archives and Educational Facilities at the Hospital was acknowledged in the study advertising flyer and was therefore known by all research participants (see Appendix G). This may have affected both the recruitment process and interview and focus group session responses. Firstly, the recruitment process may have been affected as prospective participants with disapproving views of the organisations cultural heritage may have avoided study participation due to identifying the organisational role of the principal researcher. Secondly, respondents may have assumed the researcher positively supported the collection and preservation of RPA heritage and history. As a result, they may have felt indirect pressure to provide answers they thought sympathetic towards the preservation of heritage and disinclined to provide responses that might be in opposition to those held by the researcher. An attempt to mitigate this occurred through the abstract provided to participants before the commencement of sessions (see Appendix L). The abstract suggests that any object can be defined as heritage and that value is subjective and a perspective. Also, before the commencement of each session the researcher further reminded all participants that all opinions were valid and were valued, and respondents were requested to respect one another's opinions. Concerns surrounding confidentiality were also addressed. Participants were reassured in writing before attending the interview and focus group sessions (see Appendix I) and verbally at the commencement of each session that all data was secure and confidential, and that their open opinions were sought and valued.

The hierarchical nature of the organisation was also considered a study limitation as respondents may have held back or altered opinions when in the presence of senior managers, executives, or doctors. On several occasions respondents used the phrase 'doctor is king' during interview and focus group sessions. These views may have influenced discussion in focus group sessions that contained doctors. Openly disagreeing with doctors, senior management or executive leadership strategies may in a respondent's view result in undesirable consequences beyond the study environment.

The insider position of the researcher also served as an advantage in that deep institutional knowledge and understanding of the complexities faced by the organisation add an additional layer of understanding when interpreting data. The researcher's knowledge of RPA history often permitted the immediate development of context which in turn resulted in richer probing responses and follow-up questions during interview and focus groups sessions. Further, some relationships

with study respondents were pre-established, and respondents appeared at ease during the study sessions, providing complex, detailed answers and honest opinions. Language was often relaxed, and responses flowed with little prompting required to further discussion. A further advantage was that the researcher had a detailed pre-existing understanding of the history of several of the departments where participants worked, and a detailed understanding of several of the longer-serving participant histories and associations with RPA. This enabled the development of context and deeper insight into concepts and ideas that respondents were exploring.

Due to the stipulations placed on study recruitment by the SLHD Ethics and Governance Committee, the participant study sample may be considered non-representative of the wider organisational staff body. The ethics and governance committee requested an 'arm's length' passive approach be adhered to during the recruitment process. RPA has over 6000 staff members spread across several organisational tiers and professional backgrounds. As a result, many of these were not represented in the sample of 32 participants. Missing were members from Environmental Services, Capital Infrastructure and Engineering and Digital Health Information (IT). Had staff members from Capital Infrastructure and Engineering (CIE) participated, additional insight into the complexities and issues surrounding the maintenance of built heritage and heritage spaces at the Hospital could have been explored. CIE staff members are instrumental in both protecting or destroying material heritage. Their insights and perceptions surrounding the use of heritage spaces for clinical and administration purposes may have offered an additional dimension into several of the sub-categories that emerged.

Similarly, Environmental Services is a department whose members clean, sanitise and ensure infection control practices are adhered to across the Hospital. Staff members from this department could have provided varied insights into the challenges faced by cleaning teams and support staff when following protocols and practices required by a large modern hospital within built heritage environments. They could also have provided insight into the more general cleaning of heritage artifacts like busts, statues, stained glass windows and furniture and fittings. Furthermore, environmental services staff come from diverse social and economic backgrounds. The department is largely populated by multi linguistic migrant workers from developing nations. Members from this department may have provided interesting insights previously unexplored as many may support different values and perceptions surrounding both medical institutions, government organisations and colonial derived heritage. There was, however, diversity enough represented in the study that several tiers, age groups, employment durations and professional backgrounds from across the Hospital were sampled to demonstrate variance in thought processes and opinion.

A further group of people not represented in the sample body were members of the Indigenous Australian community. RPA sits on Gadigal land occupied by the people of the Eora Nation. Indigenous people have been displaced and marginalised by the occupation of the land now taken by RPA. Indigenous Australians constitute 2% of the SLHD workforce which today is approximately 14,000 employees. RPA employs 6000 of these 14,000 staff members. Studies by Poor and Snowball (2010) and Morey et al. (2002) found colonial built heritage and Euro-centric architecture and spaces can be recognised and perceived as symbols of discrimination and a threat to racial or social minorities. Unfortunately, as no members of the Indigenous community were involved in this study, research into this area could not be examined.

Methods

This research study applied a qualitative approach to a single case example utilising a (1) pilot study focus group, (2) two focus groups and (3) 13 semi-structured one-on-one interviews.

Principal Steps

1. Ethics application and Site application
2. Recruitment
3. Pre-session stimulation
4. Pilot focus group
    a. Provide objects and images to stimulate respondents before the session began
    b. Provide questions for discussion
    c. Provide further images at select times to further motivate discussion
5. Transcribe and analyse pilot focus group
6. Focus groups
    a. Provide objects and images to stimulate respondents before the session
    b. Provide questions for discussion
    c. Provide further images at select times to further motivate discussion
7. Semi-structured one-on-one interviews
    a. Provide objects and images to stimulate respondents before the session
    b. Provide questions for discussion
    c. Provide further images at select times to further motivate discussion
8. Transcribe all sessions for analysis

Ethics Application

An ethics application was required by both the SLHD, the NSW health district within which the RPA resides, and the University of Technology, Sydney (UTS). Ethics approval demonstrates that research meets a selection of criteria which support;

- honesty, integrity and respect for human research participants, animals and the environment
- good stewardship of public resources used to conduct research
- appropriate acknowledgement of the role of all those conducting research
- responsible communication of research results

(University of Technology Sydney 2019)

Edwards and Weller (2016, p. 99) suggest that 'ethical conduct refers to moral values and behaviour; it is a foundation on which the legitimacy of social research rests'. As the study involved one-on-one interviews and focus groups it was important to demonstrate that informed consent would be obtained, confidentiality and anonymity protected, deceptive practices avoided, risk or harm minimised and the right to withdraw at any time be made available (Sim & Waterfield 2019). Participant interview parameters as a result were clearly outlined to respondents. Participants were fully informed of the study's purpose, how data would be accessed, collated and analysed, how it would be presented as a final product, and how and precisely when it would be destroyed. Participants were also informed of the use of digital recording devices and informed that all records would be stored on REDCap (Research Electronic Data Capture) as required by the SLHD Research Ethics and Governance Office. REDCap is a secure web application for building and managing online surveys and databases. Participants were also informed of the right to ask questions during the research process, withdraw from the study, withdraw their permissions, and request their transcript be deleted at any time without repercussions from the principal researcher, university or the organisation under investigation.

Within interview settings, full disclosure concerning the study's purpose, process and rules of engagement permits a clear framework be constructed from which participants can understand how the study will take place which assist in the management of expectations before commencement of sessions. Sim and Waterfield (2019, p. 3004) add however that 'focus group methodology generates distinct ethical challenges that do not correspond fully to those raised by one-to-one interviews'. Consent and disclosure are potentially problematic as 'consent in focus groups stems from the degree of disclosure that is possible' (Sim & Waterfield 2019, p. 3004). When consent is centred

around notions of autonomous decision making and the principle of respect, the influence of others can alter the nature and type of disclosure that occurs during a focus group session. Focus group sessions can on occasion become noisy and disorderly as participant views are 'shared, challenged, and truncated as participants join in, or drop out of the discussion taking place' (Warr 2005, p. 203). Similarly, power relations and personality types may cause discourse to remain centred on concepts that a participant may have otherwise terminated or avoided further exploration in. As such 'reliance on the disclosure element of consent is thereby weakened' (Sim & Waterfield 2019, p. 3005). Further to this, pre-session information disclosure may not be adequately understood by participants. While the study abstract may appear clear, comprehensible, and accessible to heritage educated and informed participants, the information supplied may still contain concepts, language and ideas that seem vague to others.

Confidentiality is a further key component of ethical research as it builds trust and instils confidence in participants. This is important on two fronts, firstly the participant feels secure in remaining anonymous and unidentified in the data. This ensures that their discussion will not result in future actions taken against them or consequences from the organisation because of research outcomes. Secondly, instilling a sense of security and trust will see a more complex and open level of discourse emerge. The immediate issue that presents, occurs through deductive disclosure as 'the more detailed the description of the research process, the data and the sample, the more difficult maintaining anonymity can be' (Edwards & Weller 2016, p. 99). While names and departments can be deidentified using numbers and letters, other indirect means of identification can still take place. For example, participants may frame discussion from a departmental perspective, or may mention names of other people associated with them or terminology frequently associated with an organisational skillset and knowledge backdrop. During one-on-one semi-structured interviews, sessions are not as simple as question–answer interaction. If the moderator is skilled at prompting, a level of discourse tends to occur, and because of the focussed nature of the interaction, the resulting data can prove rich and detailed. The more detailed the data, the greater the risk of deductive disclosure occurring. Sim and Waterfield (2019, p. 3009) also suggest that the 'outsider' researcher position may hold greater risk in that effectively identifying data at risk of breaching confidentiality may not be possible. Alternatively, it could also be argued that the 'insider' researcher role, as is the case in this study, may inadvertently lead to an assessment and reporting of the data that extends beyond that information disclosed.

Focus group sessions are also at risk of the internal disclosure of information and consequently a

breach of confidentiality. Tolich (2004, p. 101) notes that 'internal confidentiality is distinct from external confidentiality, which assures protection against identification by those who were not subjects of the research'. While the researcher may strictly adhere to processes that externally prevent identification of participants, the researcher has less control over focus group participant behaviour at the conclusion of the session. In this study, focus group participants often knew each other, so confidentiality was reliant on professionalism, and an adherence to the participant information sheet requested guidelines.

This study underwent a two-stage ethics approval process. The first stage involved the submission of an ethics application to the SLHD Research Ethics and Governance Office. This application required that several documents be developed and submitted for approval. These documents are listed below.

1. Project Protocol
2. Interview/Focus Group advertisement (see Appendix G)
3. Information for Participants' document (see Appendix I)
4. Participant Consent Form (see Appendix J)
5. Interview/Focus Group Questions (see Appendix K)

After preliminary approval, an RPA site application was submitted to the SLHD Research Ethics and Governance Office and directed to the RPA General Manager for review and approval. This was subsequently approved by the General Manager and then the Human Research Ethics Committee, approval – X19-0119 & 2019/ETH08672 – July 2020, valid to July 2025 (see Appendix M). Upon receiving this approval, a second ethics application was submitted to the UTS Research Ethics Committee containing the approved SLHD documentation. Approval was granted based on the externally ratified SLHD ethics approval with the UTS Human Research Ethics Committee providing the reference number ETH19-4052 (see Appendix N).

Recruitment and Sampling

The SLHD Ethics and Governance Office approval conditions stipulated that participants were to be sought through an 'arm's length' approach via general advertising at staff meetings and committee meetings, through a digital advertisement placed on the SLHD Intranet Noticeboard and via paper posters placed on hospital campus noticeboards. A study recruitment flyer was designed by the researcher (see Appendix G) and submitted to the SLHD Ethics and Governance Committee for

approval. During design, the flyer was passed to several departmental colleagues for review and informal feedback. Feedback suggested the flyer information was clear and concise.

The study flyer was placed on the SLHD district intranet blackboard for a two-week period. It was further placed on several notice boards and meeting room tables across the Hospital campus. The ethics committee requested that no direct approach be made to staff members for involvement in this research study. Consequently, participant recruitment occurred as a result of self-selection that was further supported via a snowball recruitment process where staff members were requested to pass information to their colleagues.

The initial advertisement stated that the study involved 'Exploring the value of cultural heritage at RPA'. It also stated that it sought participants who were employed for a minimum of five years, and that focus groups and interviews would be 60 to 90 minutes in duration. While the initial research study advertisement requested participants for both focus groups and interviews, a pilot focus group was the immediate focus, and all interested participants were directed towards a group date and time. Focus groups that precede quantitative research assist the researcher to 'learn the vocabulary and discover the thinking pattern of the target audience' (Krueger 1997, p. 39). For this reason, a pilot focus group was initially planned as it was theorised that a more complete level of understanding regarding the perceptions and values surrounding cultural heritage at RPA could be developed and explored. The pilot would also serve as a testing ground to assess the efficacy of the research strategy. Information collected from the pilot focus group would be used to further develop interview and focus group questions that would more specifically target concepts and themes considered important, a clear vocabulary be developed, and a well-defined qualitative survey constructed. This strategy was soon discarded due to the low response rate of two inquiries.

Several issues were identified early in the recruitment process. While many staff members verbally acknowledged the value of the study and informally demonstrated a keen interest in involvement, few were willing to commit to a focus group due to time constraints and availability. Other staff members proved inflexible regarding dates and times offered. An investigation into this hesitancy determined that 60 to 90 minutes per focus group was considered too long a timeframe. The timeframe was initially set to this duration to provide buffering should the sessions require it. It was theorised that it was better to run a longer session, and finish early, than run a short session, with respondents leaving before the completion of the session due to other commitments, which would result in the loss of data. The researchers organisational experience informed this decision making as

senior executives, doctors and nurses often book back-to-back meetings, or hold overriding responsibilities, meaning they would need to leave, regardless of the session being incomplete. This theory was supported during the pilot focus group study with one senior executive leaving at the 55-minute mark, citing the need to attend a teleconference.

The initial recruitment advertisement also stated respondents were to have a minimum five-year employment at RPA. Based on researcher experience within the organisation it was theorised that organisational members with a five-year history would hold the necessary organisational knowledge and insight surrounding the issues and questions explored. Through informal discussions with staff, it was determined that this excluded several staff members who wished to be involved. Due to the initial low response rate, this minimum time frame requirement was removed, and the advertisement changed to reflect sixty-minute focus group and interview sessions (see Appendix H). As a result, a pilot study group containing four people was constructed.

Pre-session Stimulation: Cultural Probes

Before the commencement of each focus group and interview session, participants were asked to arrive 10 to 15 minutes early to engage with a collection of objects that best encapsulates the diverse array of material organisational cultural heritage found at RPA (see Appendix B). Specifically selected from the museum and archives collection, and from across the Hospital campus, these objects would serve as cultural probes during the study. Cultural probes are physical tools or devices that aim to provoke both inspirational and informational responses from research participants (Gaver et al. 1999). Gaver, Dunne, and Panceti first used cultural probes in their 1999 design project exploring input and collaboration of the elderly from several diverse European communities (Robertson 2008, p. 4). Cultural probes have been adapted and appropriated for a range of purposes and projects in a number of different research fields (see Graham et al. 2007; Robertson 2008). Probes in this instance were adapted to suit the research aims of this study, which was that of exploring and understanding perceptions of value surrounding RPA's organisational cultural heritage.

The rationale behind the development and inclusion of cultural probes was twofold. The first was to highlight and remind study participants of the breadth of cultural heritage 'types' and the depth of meaning associated with the term 'organisational cultural heritage'. Secondly, they would provide a springboard into conversation and engagement. As a result of researcher insider experience and past informal discussions with organisational members, it was apparent that cultural built heritage,

one cornerstone of cultural heritage, often dominated organisational member perceptions of meaning. It was therefore considered essential to shift participants' minds away from this singular artifact to ensure that a more complete and inclusive vision of cultural heritage was acknowledged and explored.

Cultural probes offered further value in that they helped generate a mindset and mood for participants before the commencement of session questions and discussions. Although written in plain language, it was felt that the Focus Group/Interview Outline and Research Abstract (see Appendix L) provided to participants as background information might still contain overly complex ideas regarding material and non-material heritage frameworks. In providing objects derived from a variety of mediums, it was hoped that participants would feel more at ease in understanding what was being explored. To facilitate this, participants were guided to display tables exhibiting the objects. Each object was labelled with a simple description and date which was read to participants. These were read to each participant by the researcher who then retreated to allow some time for viewing and reflection. Some objects provided immediate interest and excitement to respondents who engaged in open conversation prior to the commencement of focus groups. No interaction occurred with the researcher however who had left the space. During focus group sessions some respondents began discussing objects, openly reflecting on memories and stories associated with recognised objects. These emotional responses provided valuable starting points and springboards during focus group and interview sessions. When a participant struggled in articulating thoughts regarding cultural heritage, the presence of tangible objects in the room often provided scaffolding to support their comprehension and explanation.

Schein (1991) similarly studied organisational culture through the use of session stimulators such as theoretical models. In Schein's method, the act of stimulation is reversed. Stimulation is provided by the presentation of a theoretical model first to a 'motivated group of insiders' who 'brainstorm' ideas to produce tangible and intangible organisational artifacts (Schein 1991, p. 253). The group is then further encouraged by questions and observations provided by the session moderator. This enables the moderator to push the participants to name the values implied by artifacts and 'to identify the shared underlying assumptions that lie behind the artifacts and values' (Schein 2017, p. 253). Schein (1991, p. 253) suggests that 'by combining the observations of an outsider with the analysis of group insiders' underlying assumptions can be revealed 'fairly readily'.

In this research project the theoretical model was replaced by a diverse array of material organisational artifacts. These material artifacts served abstract roles providing a means to explore organisational underlying assumptions and values and were chosen to best represent the diverse types of material heritage help by RPA. Objects were selected to represent and reflect material from multiple organisation fields within the Hospital. Specialised clinical objects, non-specialised catering objects, engineering and planning objects, organisational photography, wider organisational heritage-built spaces and art heritage were chosen.

Objects included during the pre-session stimulation (see Appendix B) included:

1. Original timber monaural stethoscope dated to circa 1895 owned by Dr Robert Scot Skirving, Prince Alfred Hospital Surgeon, and significant figure associated with the early days of RPA's development.
2. Original 1882 Prince Alfred Hospital Register of Patient Admissions and Discharges open to a random page.
3. Original 1886 handwritten RPA Nursing Gazette 'Why and Because'
4. Original 1930s RPA logo milk jug and crockery piece containing the iconic RPA emblem crest.
5. Original 1912 Schematics of RPA Nurses' Home extension
6. 2019 photograph of 1945 King George V Memorial Hospital for Mothers and Babies Statue of King George V
7. Original 1885 Prince Alfred Hospital all staff photograph
8. Original images c. 1905 including rear view of hospital, caretaker's cottage featuring caretaker, three doctors with wheeled stretcher and first Female Emergency Ward
9. 1885 Queen Victoria stained glass window
10. Circa 1950's black and white image of 1882 Administration Block cedar arches granite donation plaques and 2019 image of arches minus donation plaques
11. 2019 photograph of Kerry Packer Education Centre courtyard fountain built in 1914
12. 1896 Patient Medical Record owned by Dr Robert Scot Skirving

Object 1 - Original timber monaural stethoscope dated to circa 1895 was originally owned by Dr Robert Scot Skirving, Prince Alfred Hospital Surgeon.

Dr Skirving was a significant medical figure at both the University of Sydney Medical School and Prince Alfred Hospital. He served as medical Superintendent, as Honorary Physician, was lecturer of Clinical Medicine at the University of Sydney and at RPA. The second largest lecture theatre at RPA is named after him. This object is significant due to the historic, scientific, and aesthetic qualities it represents, and due to the stories associated with the object's owner. These stories may or may not be known by organisational members based on deeper understandings of RPA and the university medical school histories.

Object 2 - Original 1882 RPA Register of Patient Admissions and Discharges open to a random page.

This patient register is a handwritten document that captures in order:

1	Patient name	13	Disease	
2	Date of admission	14	Date of Discharge	
		15	Result	Cured
				Relieved
3	How admitted			Unrelieved
4	Age			Died
5	Sex	16	Number of Days in Hospital	
6	Married or single	17	Cost of Maintenance	Rate per diem
7	Religion			Amount
8	Native Place	18	Received for maintenance.	
9	Address	19	Cash found on person on admission	
10	Occupation	20	How disposed of	
11	Medical Officer in Charge	21	Remarks	
12	Ward			

This object and information offers both historic, educational and social value and the potential for interpretive examination. The object measures 50cm long x 37cm wide x 10cm deep, weighs 12kg and therefore also offers aesthetic value.

Object 3 - Original 1896 handwritten RPA Nursing Gazette titled 'Why and Because'.

This object offers an account of the daily lives of nurses in 1886 discussing the appointment of a new matron, requests to the medical superintendent and the allocation of gifts. It is the only remaining publication of its time and therefore offers education, social and historic value.

Object 4 - Original 1930s RPA logo milk jug and crockery piece containing the iconic RPA emblem crest.

These objects represent the mundane daily items found in the Hospital between the 1880's and 1960's when branded hospital objects began to be replaced by non-branded steel and plastic hospital crockery and cutlery. They offer aesthetic, historic, and social value and present the possibility for discussion and comparison between modern branded and unbranded mundane instrumental hospital objects.

Object 5 - Original 1912 Schematics of RPA Nurses' Home extension.

The original Prince Alfred Hospital Nurses' Home opened in 1892. The Victorian Gothic styled Nurses' Home underwent two extensions in 1914 and 1930 and a redevelopment in 2005. The original building was constructed to house 50 nursing staff members. The 1914 expansion accommodated 210 staff and the final 1930 eight story extension would see a total of 400 nurses living onsite. In 2005 the latter two extensions were demolished and replaced by a large lecture theatre and the car park and entrance to the Woman's and Babies Unit in the newly opened Clinical Services Building 89. Florence Nightingale was consulted on the plans of the original building, which was altered as per her suggestions. Many of the original features of the building are retained with minimal modern interruption or intervention. The education centre is today the central facility for organisational meetings, presentations, educational courses, and social gatherings. The plan schematics offer a glimpse into the design original design of the building. The Nurses' Home, today known as the Kerry Packer Education Centre, demonstrates historical, educational, aesthetic, and social significance.

Object 6 - 2019 photograph of 1945 King George V Memorial Hospital for Mothers and Babies Statue of King George V.

The white marble King George V statue sits in the centre of the single pathway that leads to the front entrance of the RPA Hospital main administrative KGV building 13. The statue stands at 1.8 metres high on 1.5 metre sandstone pedestal. The gardens, pathway and access road surrounding the statue are the original shape and design. The statue positioning and height is specific and

intentional standing prominent at the entrance to the original King George V Maternity Hospital for Mothers and Babies. The statue offers social, aesthetic, and historical significance.

Object 7 - Original 1885 RPA all staff photograph

The 1885 all staff photograph is one rarely seen by staff members. This image includes staff porters, nurses in training who were also hospital cleaners, sisters, doctors, guard, caretakers, kitchen staff, laundry staff, matron, chief superintendent, and child labourers. It is one of two remaining Victorian era all staff images and presents social and historical value.

Object 8 - Original images c. 1905 including rear view of hospital, caretaker's cottage featuring caretaker, three doctors with wheeled stretcher and first Female Emergency Ward.

These original fabric images were selected as they show the external hospital campus from a collection of angles, various staff and the first female emergency ward.

The rear campus image shows the now demolished C and D Block Pavilions and the Princes Operating Block in the centre. The foreground contains the Laundry Block with sheets hung on the drying lines. Another separate well-known image of the laundry has been used in books to illustrate the enormity of labour surrounding laundry duties at the Hospital. It was thought this image would provoke discussion surrounding the old campus structure and the laundry.

The caretaker's cottage was located in the main Hospital driveway to the right of the main entrance until demolition in the 1930's. The Hospital caretaker in the image held a significant role who served at the Hospital for over twenty years. This role was instrumental to admissions and discharges at the Hospital ensuring arrivals and departures went smoothly. It was thought this image would provoke discussions surrounding past roles within the Hospital and built heritage.

The image of the two doctors attending a third on the stretcher has in the past been interpreted as young doctors having fun. This image was taken on the lower elevated walkway between the Princes Operations Block and C Block Pavilion. It also shows St Johns College in the background. It was thought this image would provoke discussion surrounding young doctors in training and built heritage.

The image of the first Female Emergency Ward illustrates the various components of Victorian/Georgian era hospital wards and was included to promote discussion around changes in clinical practice, nursing and built hospital environments.

Together, these images represent social and historical value highlighting various aspects of the Hospital around 1905. They also offer aesthetic value as they fabric backed photographic images and are rare within the collection.

Object 9 – 1885 Queen Victoria stained glass window.

The Queen Victoria stained glass window is visible in the southern hallway inside the main entrance of the Hospital and was installed in 1885. Donated by Mr Maurice Alexander, the window depicts a formal representation of Queen Victoria. She is wearing a fur trimmed gown and crown, blue sash and order of the garter and holding a sceptre in her right hand and a scroll in her left bearing the words Prince Alfred Hospital. Behind her is a yellow and green foliate border which displays the names of her husband, Albert the Good, and nine of their children. This window is one of over twenty located across the Hospital and combines both art and heritage, offering social, historical and aesthetic value. RPA contains an Arts in Health program named Arterie, and art heritage is peripheral to this program. It was thought the inclusion of this window would promote discussion surrounding the value of heritage as art.

Object 10 - Circa 1950's black and white image of 1882 Administration Block cedar arches granite donation plaques and 2019 image of arches minus donation plaques.

These arches were originally located in the hallway between the 1882 built Administration Block and the now demolished rear Kitchen and Princes Blocks. The first image shows the arches in original position with four large granite plaques engraved with hospital benefactor and subscriber names. The second image shows the same arches temporarily positioned in a similar position in preparation for reinstalment, and reinterpretation as a heritage artwork. Glass panels are to be installed in place of the granite plaques, which have all since been since lost except for half of one panel. The glass panels will be artist designed featuring staff prominent to the history and development of RPA. This installation offers social, historic, and aesthetic value. It was thought inclusion of this would stimulate discussion surrounding the preservation of sections of built heritage, heritage as art, and the varying perceptions and values surrounding hospital staff members.

Object 11 - 2019 photograph of Kerry Packer Education Centre courtyard fountain built in 1914.

The Kerry Packer Education Centre courtyard was constructed in 1914 during the first major redevelopment and extension of the 1892 Nurses' Home. This courtyard was originally designed as a breakout space for nursing staff who traditionally completed long split shifts. The courtyard was preserved after the demolition of the extensions and the construction of the Clinical Services Building and the Women and Babies Unit entrance. The space is maintained by Capital Infrastructure

and Engineering Gardening Services and is still used by staff for breaks and as a breakout space for the education centre. It is also used for all staff BBQ's and other large celebratory staff events. It was hoped the inclusion of this image would promote a discussion surrounding staff events, breakout spaces in the Hospital and staff mental health and wellbeing. It offers both historical, social and aesthetic value.

Object 12 - 1896 Patient Medical Record owned by Dr Robert Scot Skirving.

The 1896 Patient Medical Record is the only surviving document of its kind offering educational, social, and historical value. It was thought the inclusion of this object would promote discussion surrounding clinical processes and change, and the medical profession in general.

Session Stimulation

During the interview and focus group sessions four A4 photographs were presented for analysis and discussion (see Appendix C). These images included.

1. 1914-built Nurses' Home quadrangle fountain
2. 1882-built RPA front hall and foyer displaying several movable heritage items including granite and marble busts, portraits, and plaques
3. 1880-built Pathology building 93 (not heritage listed)
4. 1941-built King George V Memorial Hospital for Mothers and Babies operating theatres located in the RPA Museum.

Object 1 - 1914-built Nurses' Home quadrangle fountain.

The quadrangle fountain was installed during the 1914 Nurses' Home redevelopment and first expansion. As previously noted, the area served as a breakout space for nursing staff to rest and relax between shifts. The fountain is maintained and still functioning today and is a central point for many education centre and staff events. It offers both historical and social value. It was thought the inclusion of this image would prompt discussion surrounding the modern use of heritage spaces, and their retention during times of redevelopment.

Object 2 - 1882-built RPA front hall and foyer displaying several movable heritage items including granite and marble busts, portraits, and plaques.

The 1882 built Administration Block front foyer and entrance to the Hospital is a significant and prominent feature of the Hospital. It is one of four entrances used to access the Hospital but is the main entrance trafficked by staff. The space contains fourteen stained glass windows, marble busts of staff prominent in the development of RPA and portraits. It also contains original architectural features including corbels, transoms, architraves, and marble flooring. The area offers significant social and historic value highlighting both movable and built heritage. It was thought the inclusion of these images would prompt discussion surrounding the value of maintaining the original entrance to the Hospital and the surrounding complexities associated with it.

Object 3 - 1880-built pathology building, image c. 1930.

The Pathological Building and Morgue was the first building constructed on the Hospital campus in 1880. It has since housed several departments across time including Pathology, Medical Student Housing, the Belisario Institute of Dermatology, and has since returned to Pathology. It is due for demolition in 2024 to make way for the $750 million hospital redevelopment. The building is not heritage listed however has been perceived as a beautiful building by staff due to its aesthetic qualities as its front is covered with ivy. Earliest photographic records suggest its walls have been covered with ivy since the 1890's. Above the entrance is a sandstone relief of a cherup, two ornate corbels and text carved in sandstone. The text reads 'In coelo quies est' – 'in heaven, there is rest'. It was thought the inclusion of this image would prompt discussion surrounding the redevelopment and demolition of the Pathology building and the nearby 1955 built chapel.

Object 4 – 1941 built King George V Memorial Hospital for Mothers and Babies operating theatres located in the RPA Museum.

The King George V Memorial Hospital for Mothers and Babies, today known as the KGV Administrative Building 13 contains two operating theatres that doubled as educational facilities. These theatres are located inside the RPA Museum on level 8. The internal dome of the theatres contains fourteen viewing windows that are accessed on level 9. Nurses and doctors in training were required to view one hundred births and participate in twenty during their training. These operating theatres feature in the RPA Museum, with one room staged as it would have looked in the 1970's. Two images have been included. The first is of the original theatre taken in the early 1940's and the second is the theatre as it looked in 2021. It was thought the inclusion of these images would promote discussion surrounding the museum and the retention of built heritage spaces. The images offer social, historical, and educational value.

Pilot Study Focus Group

Research demands researcher accountability and as full-scale studies require significant input of both financial and physical resources; every attempt should be made to minimise unanticipated problems. Pilot studies provide 'specific pre-testing of a particular research instrument such as a questionnaire or interview schedule … and are a crucial element of good study design' (Van Teijlingen & Hundley 2002, p. 1). They usually consist of small-scale experimental rehearsals that aim to replicate the proposed full-scale main study (Sarantakos 2012), and are primarily concerned with exposing administrative and organisational problems surrounding the study and the respondents. Thabane et al. (2010, p. 1) suggest the main goal of a pilot study 'is to assess feasibility so as to avoid potentially disastrous consequences of embarking on a large study – which could potentially drown the whole research effort'. Through this, pilot studies can provide advance warning regarding possible weaknesses or areas that may fail in the main research project.

More specifically, pilot studies identify unforeseeable logistical and practical issues such as questionnaire distribution, collection, and secure storage. They may also be used to uncover 'local politics or problems that can affect the research process' (Van Teijlingen & Hundley 2002, p. 2). For example, interviewing senior executive staff and including them in focus groups can prove problematic due to time constraints and their limited availability. Furthermore, in hierarchical organisations such as that of a large hospital like RPA, staff participating in focus groups may experience indirect pressure to answer differently or simply feel uncomfortable due to the presence of more senior staff members. Organisations such as RPA experience numerous competing priorities and personalities, and as a result, organisational politics can greatly affect member behaviour.

Additional reasons for performing pilot studies as suggested by Sarantakos et al. (2012) and Veal and Darcy (2014) were to:

- estimate main study resources including cost, staff, and duration;
- demonstrate sampling frame as adequate;
- estimate success of recruitment process and respondent dropouts;
- provide researchers with real-world practice;
- test respondent response and to gain familiarity with respondents;
- assist in development of research plan;
- test fieldwork arrangements; and
- assist in compiling evidence to convince stakeholders of main study validity and viability.

Semi-structured One-on-one Interviews

In-depth interviews require a carefully planned sequence of questions that frame larger questions within the research. Greenbaum (1999, p. 17) further adds that 'the format offers the researcher the ability to probe in-depth with the participant'. The specific questions are usually referred to as an interview guide. This guide can be provided to participants before the interview, which can strengthen the dependability of the results and therefore the research (Bell et al. 2018). The semi-structured nature of this type of interview may also capture variations in responses that more accurately reflect individual employee perceptions, and that are not influenced by other respondent opinions. Variations in response may be pursued and cues given to further develop respondent thought processes and theories. A variety of question types may be utilised to elicit responses including probing questions, closed questions, open-ended questions, leading questions and neutral questions (McMurray et al. 2004). Veal and Darcy (2014) suggest in-depth semi-structured one-one-one interviews usually consist of a relatively small number of respondents, a checklist of topics for guidance, may take from 30 minutes up to several hours, and may require follow-up sessions. The sessions should be recorded to ensure transcripts can be accurately transcribed for clear coding and analysis.

Interviews as a research method pose both challenges and benefits. One significant advantage to interviews relates to the personal nature of the activity. The interviewer communicates directly with the respondent, and where possible can develop an almost conversational level discussion. This removes or minimises any feeling of formality on the part of the respondent. This is particularly important within this study, due to the researchers position within the organisation under investigation. Consequently, the researcher is undergoing what is termed insider research in which the researcher investigates their place of work (Savin-Baden & Major 2013). The researcher can claim what Tierney (1994, p. 141) labels as 'insider status'. Tierney (1994, p. 141) suggests that due to this positionality, respondents tend to feel less inhibited in discussion and can talk more freely. Issues however arise with this status through the blurring of boundaries between researcher and the researched, as an unhelpful level of bias may exist or develop. Eisenhardt and Graebner (2007, p. 28) suggest however that 'a key approach to limit bias is using numerous and highly knowledgeable informants who view the focal phenomena from diverse perspectives'. In other words, that the study should include organisational members from diverse hierarchical and functional levels of the organisation. A further issue surrounding the insider position may occur due to preconceived notions regarding the respondent, or the questions presented in the interview. As a result the researcher may make false assumptions, may miss vital information or misinterpret data (Savin-

Baden & Major 2013). The respondent may also make false or misleading statements in the hope the responses are what they wish to hear (Yin 2017).

Interview questions in this study were developed to elicit responses that would explore participant perception of organisational cultural heritage and were aimed to reveal perceptions of value. These interview questions included the below:

1. How long have you worked at RPA?
2. When you think about RPA's cultural heritage, what comes to mind?
3. What does RPA's cultural heritage mean to you?
4. What does this image mean to you? (present images for review)
5. What value is there in RPA's cultural heritage? (hand out images of the 1880 pathology building, RPA Museum and 1882 Old Nurses Home Courtyard Fountain)
6. How is RPA's cultural heritage used?
7. Could RPA's cultural heritage be used differently?
8. What do you think is one more thing I should ask in the next workshop?
9. When I write up my report of this session, what should I pay particular attention to?

Focus Group Sessions

Within focus group situations the interviewer becomes the facilitator or convener of the discussion, rather than the interviewer which is a more peripheral role (Veal & Darcy 2014, p. 262). Focus groups are a guided discussion led by a facilitator where respondents answer a set of questions. The facilitator guides the discussion ensuring it remains on topic and that all areas are adequately covered. The session is recorded and transcribed later for coding and analysis. Sessions are usually comprised of between five and 12 respondents in an informal setting. Location is often a key aspect of effective focus group research as respondent comfort, access and levels of distraction require consideration (Smith 1972). This point required careful consideration when in preparation for this research project. Hospital environments are commonly stressful and unrelenting institutions regarding their central purpose. Doctors and nurses carry pagers and mobile phones that cannot be switched off. Senior executive staff generally need to be always accessible by junior staff. Meetings

can be convened at short notice thereby making staff unavailable, and meeting rooms can be reallocated as required at any time. These possible issues were addressed by setting focus group sessions in the District Finance Meeting Room, which is away from clinical and senior executive spaces. The District Finance Meeting room is carpeted modern meeting room containing a large modern boardroom table, eighteen chairs, a 100-inch television screen, four windows and several wall mounted white boards.

Focus groups offer multiple benefits and challenges to a researcher as they are a fast, economical and efficient method of collecting data from multiple respondents (Krueger 2014). The advantage of the focus group is that responses occur more readily in more natural social situations where dialogue can move freely between participants, be more spontaneous and produce 'data that would be less accessible without that interaction' (Morgan 2018, p. 5). Perspectives and opinions are dynamic, and as a consequence can shift during a discussion as a result of group interaction (Morgan 2018). This dynamic often provides a space for respondents to build on one another to better develop thoughts or trigger ideas which may have previously been difficult to articulate.

Femdal & Solbjør (2018, p. 1) further adds that 'focus group interviews take place within a complex and dynamic social context where group interaction is of great importance for the co-constructions of meaning'. Unlike interviews, the goal of the focus group is to have respondents interact with one another in addition to the facilitator, with the aim of eliciting a more complex discussion and level of discourse within a non-threatening environment. Such non-threatening environments seek 'to provoke self-disclosure amongst participants' (Krueger 1997, p. 23). Belzile and Öberg (2012, p. 1) claim there is a 'tacit division between researchers who view participants primarily as individuals sharing held truths, and researchers who view participants as social beings co-constructing meaning while in the focus group'. By viewing focus group participants as social beings co-constructing meaning the researcher can identify both advantages and disadvantages to the research method. The researcher can look to exposing and exploring the more complex interactions that occurred during the sessions and thus ultimately gain a better insight into the resulting data.

Like interviews, focus groups pose numerous challenges during research. Respondents may not be as honest in a focus group environment as they might in a one-on-one interview. Issues with organisational staff dynamics and relationships cannot necessarily be identified and as a result respondents may minimise engagement in the exercise or feel silenced (Kitzinger 1994). Focus groups may also provide a platform for respondents to air grievances or disagreements regarding

organisational management and strategy or use the space to create debate that deviates from the central questions being explored. Savin-Badin & Major (2013, p. 389) argue 'they are not an appropriate substitute for interviews, as the two have very different purposes (individual interviews serve to explore how individuals make meaning, whereas focus groups serve to gain understanding about group consensus)'.

Data Collection

Due to organisational member limitations, data collection occurred in several stages across a three-week period. Interviews were booked and focus group sessions built and booked as they became available. The District Finance Meeting Room was booked for focus group sessions. This location was chosen due to its availability, and close proximity to the RPA Museum, which meant the limited portage of delicate museum objects required in the study. Due to the challenges of booking private spaces, all one-on-one interviews took place in the researcher's office. The researcher's office is a carpeted modern office located on the same floor as the museum but in a different area. It contains standard office equipment including a computer, a large whiteboard, and a small round table with a spare chair for visitors. During focus group sessions, museum objects were displayed in the room (see Appendix D). During interviews, objects were placed on a table in the museum administration office. All focus group and interview sessions were held at 12 or 1 pm to accommodate lunch break attendance for staff.

Audio-recording Sessions

The District Finance Meeting Room and the researcher's office contain carpet and fabric-covered chairs which assisted with sound absorption and the reduction of echoes common to most hard laminate hospital floors. Sessions were recorded using two digital audio-recording devices to ensure complete capture should one device fail. A Zoom H5 Portable Field Recorder containing two high-quality X/Y unidirectional condensers served as the principal device. A Zoom iQ7 microphone with a rotating mid-side capsule and dual condensers attached to an iPhone SE served as the support device. The primary device relied on batteries whereas the support device was hard wired to a charger and general power outlet. This approach proved invaluable during one focus group session. Batteries failed and the Zoom H5 stopped recording mid-session. This was not observed for three minutes due to the animated nature of the session dialogue. The support device provided the missing dialogue. Both devices were placed centrally to all participants on the table and were situated on a small foam board to avoid capturing chair and desk noise created by finger tapping on

tables, feet hitting tables, rings on laminate or steel edging or any other vibrational noises that could interfere with respondent voices. A photograph was taken of the room to ensure participant voices could be matched to names. Tests were performed before each session to ensure devices were working and that recording levels were adequate.

Pilot Study Focus Group

The pilot study focus group completed at RPA involved four participants and went for 60 minutes. A meeting room with a boardroom table was selected as the venue. Participants were asked to arrive 10 minutes early to engage with a collection of objects. These objects represented a wide selection of RPA organisational cultural heritage (see Appendix B). Items placed around the table for participant interaction are listed below. Latex gloves were supplied should anyone wish to handle objects.

1. Original timber monaural stethoscope dated to circa 1895 owned by Dr Robert Scot Skirving, Prince Alfred Hospital Surgeon, and significant figure associated with the early days of RPA's development.
2. Original 1882 Prince Alfred Hospital Register of Patient Admissions and Discharges open to a random page.
3. Original 1886 handwritten RPA Nursing Gazette 'Why and Because'
4. Original 1930s RPA logo milk jug and crockery piece containing the iconic RPA emblem crest.
5. Original 1912 Schematics of RPA Nurses' Home extension
6. 2019 photograph of 1945 King George V Memorial Hospital for Mothers and Babies Statue of King George V
7. Original 1885 Prince Alfred Hospital all staff photograph
8. Original images c. 1905 including rear view of hospital, caretaker's cottage featuring caretaker, three doctors with wheeled stretcher and first Female Emergency Ward
9. 1885 Queen Victoria stained glass window
10. Circa 1950's black and white image of 1882 Administration Block cedar arches granite donation plaques and 2019 image of arches minus donation plaques
11. 2019 photograph of Kerry Packer Education Centre courtyard fountain built in 1914

12. 1896 Patient Medical Record owned by Dr Robert Scot Skirving

Interview Protocol and Questions

The sessions began by confirming with participants that the Participant Information Sheet and Research Study Abstract (see Appendix I and Appendix L) had been read. All responded in the affirmative and participants were reminded that it was a safe space, that people were free to provide their opinions without repercussions and that all responses would be confidential and participants de-identified. Participants were further reminded that the study aimed to explore the value of cultural heritage at the Hospital 'as they saw it'. The fundamental question explored was that of 'What is the value of RPA's cultural heritage to the organisation?' The following key questions were then introduced and explored over a period of 60 minutes. The questions were broad and open-ended, framed around the core research question. Follow-up questions and prompts were provided as necessary to expand ideas, themes or opinions.

1. How long have you worked at RPA?
2. When you think about RPA's cultural heritage, what comes to mind?
    a. Why? (importance/relevance)
    b. What makes it cultural heritage?
    c. When does it become cultural heritage?
        i. If we put a logo on it, how does that change things? Show 2018 pen with SLHD branding.
3. What does RPA's cultural heritage mean to you?
    a. When you first arrived at RPA what did you think of the facility's cultural heritage?
    b. When a new staff member or patient first visits RPA what image do you think we should be projecting.
4. What does this image mean to you? Show image of Administration Building's original 1882 foyer.
5. What value is there in RPA's cultural heritage? Hand out pathology building image, RPA Museum image, 1882 Old Nurses' Home Courtyard Fountain.
    a. Are there any complexities surrounding this vision of RPA?

    b. Are buildings fit for purpose?

6. How is RPA's cultural heritage used?
    a. In what way does it influence the type of staff we attract?
    b. Does it attract a higher quality of staff?
7. Could RPA's cultural heritage be used differently?
8. What do you think is one more thing I should ask in the next workshop?
9. When I write up my report of this session, what should I pay particular attention to?

Pilot Study Results

After transcribing the pilot focus group study, the transcript underwent preliminary open coding to explore the data and identify areas of concern. Upon completion of open coding, a Microsoft Excel spreadsheet was created containing the entire open code list as exported from the original Microsoft Word transcript. The codes were grouped to drill down on replica or similar codes that could be folded together to constitute a more carefully articulated set of open codes. A code book was then developed and used to guide the open coding of the remaining transcripts. This code book remained an iterative process. When new codes were discovered, they were added to the list.

It was determined the questions were appropriate as the data proved rich with themes and concepts. There were, however, some minor power dynamics displayed in the presence of an organisational senior executive. This individual was highly educated and insightful regarding the study questions. On occasions when small silences occurred, the individual demonstrated strong leadership qualities in leading the focus group towards new concepts and themes. This individual did not, however, dominate or drive the discussion. As a result, the focus group and questions were both considered a success. No changes were considered necessary.

Semi-structured Interviews

Participants for interviews were sourced via self-selection which was further supported by a snowball recruitment process. The recruitment process initially proved extremely slow, with only four participants requesting involvement in the research study. After interviewing these four participants, and wider casual conversations with staff, it was determined that the five-year employment criteria were excluding many organisation members who wished to participate.

Consequently, the advertising was changed removing this criterion. Nine more interviews were then captured. These interviews ranged from 25 to 50 minutes, with an average interview of 39 minutes. Six of these participants came from one department but ranged in employment duration from four months to 32 years. Other participants interviewed included senior administration executives, nursing staff, senior doctors, communications executives, organisational strategic officers and allied health staff.

It was determined early in the interview process that the RPA Register of Patient Admissions and Discharges failed to reproduce quality data as it had previously done in the pilot study focus group. During the pilot study the Patient Admissions and Discharges register evoked discussion regarding gender bias, patriarchy and white Australia. Patient names were identified and theorised as white European or other, which led to further discussion surrounding the patriarchal nature of hospitals, doctors, and surgeons. During the first two interviews, the same document failed to elicit complex discussion and was viewed as a record keeping tool. This object was replaced by a document displaying three photographic images taken of the original 1882-built Administration Building front foyer. The register did, however, remain in the pre-session stimulation collection as it continued to evoke an emotional response.

Focus Groups

Two focus groups were held with groups of six and nine participants. These groups went for 55 minutes and 60 minutes each, with some participants leaving sharply at the 60-minute mark. Both focus groups contained a mixture of organisational members representing multiple careers and hierarchical positions at RPA. Representations included nurses, senior doctors, senior administration executives, volunteers, administration coordinators, allied health staff and educational support staff.

Data Storage and Confidentiality

All hard copies of signed participant consent forms were stored in a locked desk drawer in the researcher's office on level eight of the King George V building at RPA Hospital. Environmental Service staff cannot access this space without consent.

As per the study ethics approval, all electronic interview and focus group recordings and transcripts were uploaded to REDCap for secure storage and access. All data was transcribed and participants

deidentified. Deidentified transcripts where then loaded into NVivo-12 for comparative analysis and exploration on a password-enabled laptop.

Data Analysis

Transcribing Data

Transcription is the act of converting audio recordings such as interview and focus group sessions into verbatim text. Seminal work into qualitative research transcription processes by Ochs (1979) claimed that transcription is a 'selective process reflecting theoretical goals and definitions'. This explanation has since expanded in the literature to suggest the process is also interpretive and representational. Davidson (2009, p. 37) suggests that 'important differences in the literature relate to distinctive theoretical and methodological positions about how transcription should represent language and how researchers approach transcribing language to understand the world'. The assumptions of the researcher therefore shape the act of transcription (Mishler 1991). Dubois (1991) further argues transcription not only reflects theory, but also shapes it 'because it's impossible to accurately record all features of talk and interaction from recordings, all transcripts are selective in one way or another' (Davidson 2009, p. 38).

Transcription processes are in some cases simple acts of converting language to text with the aim of exploring meaning through the examination of words. Kowal & O'Connell (2014, p. 66) add however that 'the generic term transcription here refers to any graphic representation of selective aspects of verbal, prosodic and paralinguistic behaviour'. Transcription can also constitute a detailed complex iterative process of investigation. Frost (2011) notes the latter may involve multiple rounds of transcription, each round with a specific goal in mind. First attempts at transcribing data may look towards capturing plain language including the uttered words, ums and ahs, tears and laughter, while later attempts may seek to locate fillers, pauses and false starts (Kowal & O'Connell 2014). Transcription in this study aimed to capture plain language and to explore where possible deeper meaning through tonal change and false starts. It Is important to recognise that 'transcription is constructed in a perpetual tension between authority and authorship' (Vigouroux 2007). Due to the researcher insider perspective and organisational role, it was thought respondents may filter their responses during sessions leading to bias.

Constant Comparative Analysis

Constant comparison refers to the continual process of comparing data from all sources (Glaser 1965). While this study was not strictly a grounded theory study but one that utilised key principles of the methodology, a comparison of collected data still occurred. At the conclusion of each interview or focus group, where possible and as time permitted, digital recordings using Microsoft Word were transcribed before the next session. On some occasions this was not possible as sessions were booked the following day, and most transcriptions exceeded 8000 words. The immediate transcription of sessions 'enables the researcher to develop expertise in the specific nuances of the data collection process and to shape the approach for subsequent interviews' (Daengbuppha et al. 2006, p. 375). Daengbuppha (2006, p. 375) suggests that this allows the researcher to focus and explore in greater depth the significant issues as they emerged.

Participants

A total of 32 participants were involved in the study. Three focus groups including the pilot focus group containing four, six and nine participants and 13 one-on-one interviews took place.

Table 1 was developed to explore the nature and character of respondents without breaching ethical anonymity. Data in the table include interview and focus group session duration, department type, years employed and gender. It was thought that years employed, and session duration may offer additional insight into content, as would understanding the diversity of organisational staff involved in the study. During this editing phase, all transcript word documents were styled and formatted the same regarding headings and names to ensure a standardised design and ease of use in NVivo-12. Respondents were relabelled according to their interview number and focus group. For example, pilot focus group respondent one was labelled as PFG R1, focus group two respondent nine was labelled as FG2 R9, and interview respondent three labelled as IR3.

Table 1 Study Sample (source: Author)

Sample	No	Duration (min)	Department	Years employed	Gender	Session
Pilot Focus Group	1	60	Education	13	F	PFG R1
	2		Education	22	F	PFG R2
	3		Education	12	M	PFG R3
	4		Education	16	F	PFG R4
Focus Group 1	1	65	Executive	14	F	FG1 R1
	2		Nurse	12	M	FG1 R2
	3		Doctor	23	M	FG1 R3
	4		Doctor	40	M	FG1 R4
	5		Administration	17	F	FG1 R5
	6		Administration	11	F	FG1 R6
Focus Group 2	1	60	Administration	9	M	FG2 R1
	2		Executive	17	M	FG2 R2
	3		Volunteer	13	M	FG2 R3
	4		Volunteer	7	M	FG2 R4
	5		Administration	10	F	FG2 R5
	6		Administration	16	M	FG2 R6
	7		Administration	12	F	FG2 R7
	8		Administration	10	M	FG2 R8
	9		Administration	9	F	FG2 R9
Interviews	1	46	Executive	25	F	IR1
	2	43	Executive	34	F	IR2
	3	46	Allied Health	19	F	IR3
	4	32	Nurse	9	F	IR4
	5	35	Administration	26	M	IR5
	6	35	Executive	30	M	IR6
	7	43	Executive	2	F	IR7
	8	34	Allied Health	16	F	IR8
	9	31	Allied Health	4	F	IR9
	10	27	Allied Health	1	F	IR10
	11	24	Allied Health	0.5	F	IR11
	12	33	Allied Health	2	F	IR12
	13	48	Allied Health	14	F	IR13
Total	**32**					
Average		**41.375**		**14.5**		

Demographics

Participants varied in age and experience to include graduate health professionals in their early 20s to senior health professionals in their 60s. Two volunteers in their 70s participated in focus group two. The average participant employment period was 14.5 years. Of the 13 interviews that occurred, 55% were participants from allied health departments. Focus group sessions were quite evenly spread, with participants coming from diverse backgrounds within the organisation. Absent from the research body were members from the Capital Infrastructure and Engineering Department, and from the Environmental Service teams.

Apart from the two hospital volunteers, all participants were employed on a full-time basis, and worked directly for RPA Hospital within the SLHD, or were a part of the district executive management team based at RPA. The district executive team manage five hospitals including RPA, and numerous community health centres within the local health district. No casual or part-time employees participated in the sessions.

All participants were university educated with two speaking a language other than English. All participants spoke English as their primary language, and there was a significant bias towards white Anglo-Saxon heritage. Twenty of the 32 participants were female.

Data Management

Due to the large amounts of data produced during interviews and focus groups it was deemed necessary to utilise the computer software programme NVivo-12 to better facilitate data analysis. NVivo-12 is a qualitative data analysis software package designed for multimedia and rich text-based content to allow rapid search and cross-referencing of codes and concepts. NVivo-12 is not designed to specifically analyse data but instead aims to provide a set of tools to assist in the undertaking (Jackson & Bazeley 2019). Data such as the interview and focus group transcripts developed during the project were imported into and managed within the software. All transcripts were copied and edited replacing respondent names with a new identifying name. NVivo-12 enabled line by line transcript analysis to develop codes, an ability to identify and categorise further sources against each code, permitted the rapid search and retrieval of data from within coded documents, and a means to efficiently refine the coding process. All transcripts were initially rough open coded using Microsoft Word and the annotation feature with the aim of bringing the researcher closer to the data, and to assist in determining when data saturation was achieved. This exercise proved

extremely valuable as rough codes were both included and discarded with increased efficiency, making NVivo coding a smooth process.

Coding Strategy

Preliminary Analysis Using Microsoft Excel and Microsoft Word

Strauss and Corbin (2015, p. 103) suggest that the 'first step in theory building is conceptualising'. In line with this concept, preliminary exploration took place during the initial transcription phase of the interview and focus group session recordings. As transcribing occurred memos and notes were jotted down and highlighted on the Microsoft Word page. Once a transcription was completed it was re-read and using Microsoft Words annotation feature, was rough open coded. This allowed some immediate insight into each session's data before the next session took place. This strategy again brought the researcher closer to the content. It also highlighted possible areas of interest that could be further developed during interview or focus group sessions, should a respondent introduce a new idea (Silverman 2014).

Open coding required that each line, sentence, or paragraph be allocated meaning via a word or phrase. Glaser suggests open coding should involve 'coding the data in every way possible' (Glaser & Holton 2004, p. 13). This action forces a real intimacy with the data and deeply connects and grounds the researcher to the text. It also demonstrates researcher integrity and provides credibility to the project as it preserves the participant experience that if ignored reflects an outsiders view as opposed to an insider's view (Charmaz 2014).

Each code was annotated in the comments column and linked to the relevant section of text. Figure 29 displays one section of coding as applied to Interview 12. Figure 30 displays another section as taken from Focus Group 1. Statements and quotes of interest were also highlighted for further exploration later. In an effort to run the data open, both descriptive and analytic codes were developed (Glaser & Holton 2004, p. 13). No concepts, regardless of appearing irrelevant, were overlooked, or ignored. This process was 'deliberately open so as not to close down any directions a future theory might take' (Urquhart 2013, p. 23). There are many ways to code a word, phrase, or sentence. The thesis question was kept in sight, pasted to the side of one computer monitor screen throughout this process, to ensure key statements and concepts directly concerning it were focussed upon, highlighted, and not overlooked.

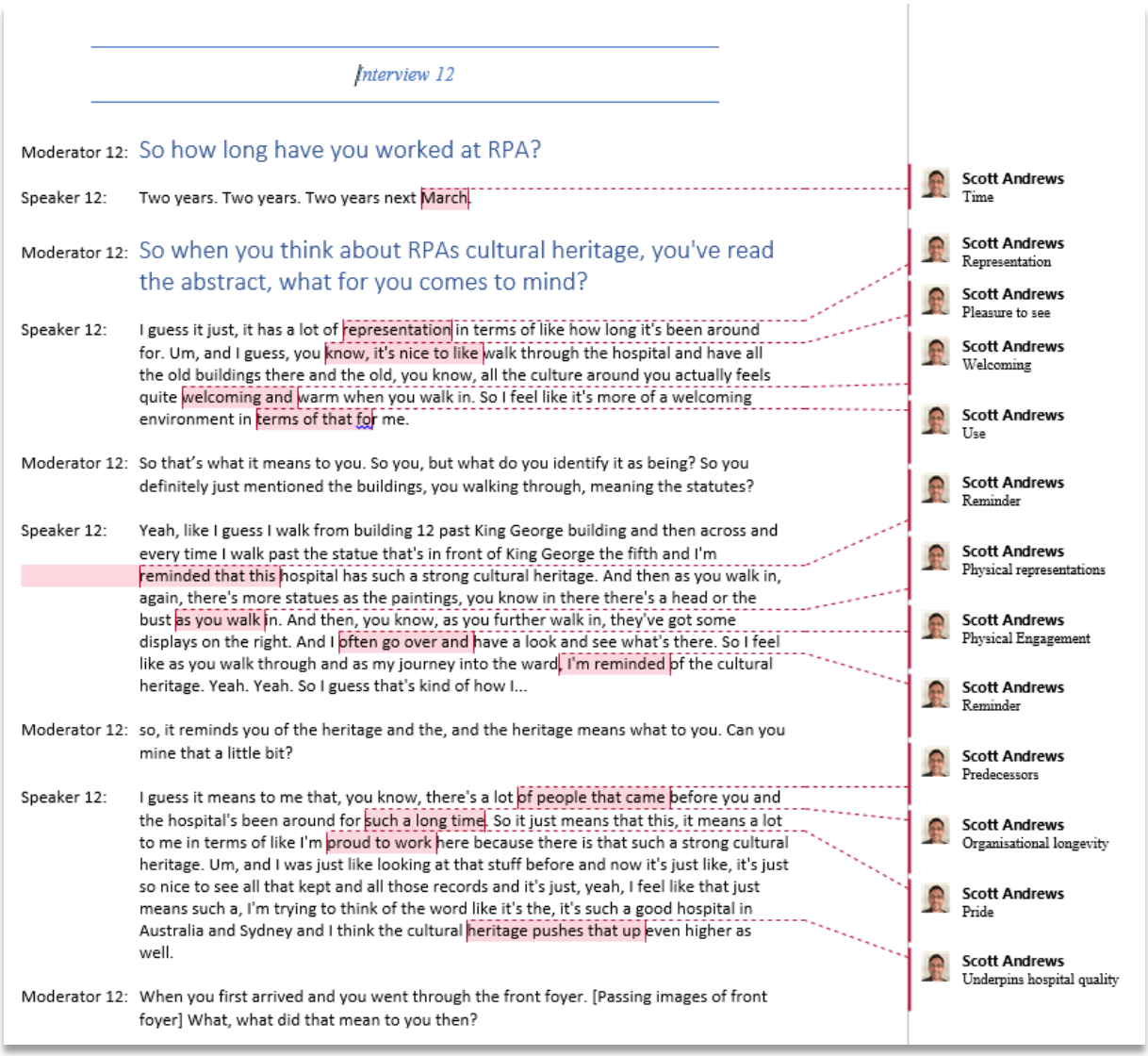


Figure 29 Preliminary Open Coding Sample 1 (source: Author)

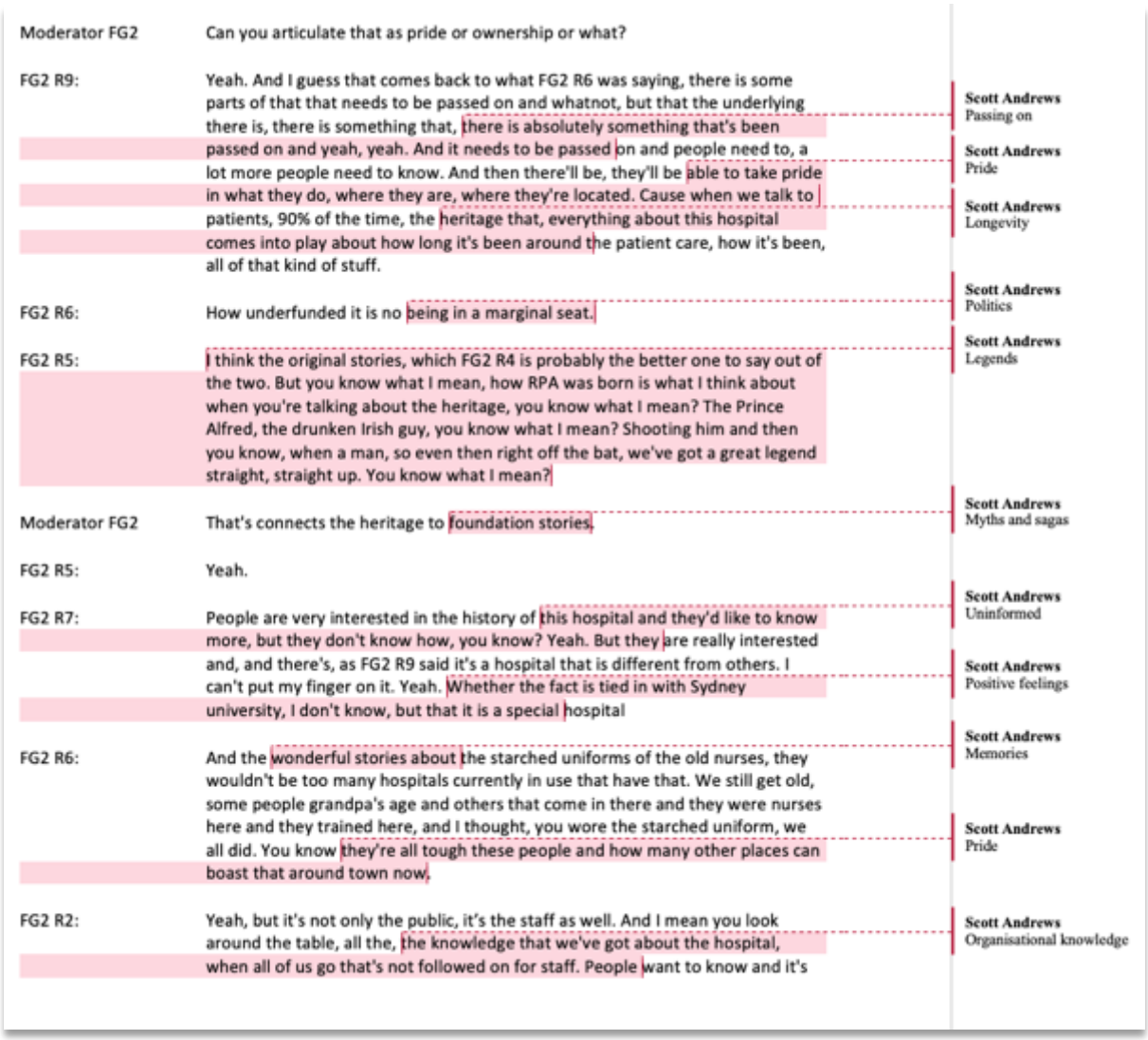


Figure 30 Preliminary Open Coding Sample 2 (source: Author)

A Microsoft Excel spreadsheet was constructed to document preliminary rough descriptive and analytic open codes and first impressions. These were then analysed and reshuffled to resemble loose themes. These preliminary themes were:

1. Emotional response to cultural heritage
2. Defining of cultural heritage
3. Meaning of cultural heritage
4. Purpose of cultural heritage
5. Value of cultural heritage
6. Issues with cultural heritage
7. Use of cultural heritage.

This strategy immediately highlighted repeating and common concepts, including ones that overlapped. Results from this spreadsheet are available in Appendix A.

In Vivo Codes

In vivo codes refer to codes that are directly derived from a participant's language. Strauss (1987, p. 33) notes 'in vivo codes tend to be the behaviours or processors that will explain to the analyst how the basic problems of the actors is resolved or processed. These codes fracture the data directly because they represent analytic categories as used by the researcher.' As such they can in most instances be immediately categorised as selective codes. Urquhart (2013, p. 103) adds that in vivo codes 'provide instant authenticity as the naming comes directly from the participant'. Such coding ensures the concepts are firmly grounded in the research participants own words. Consequently, wherever possible, in vivo codes were sought and utilised, ensuring data interpretation remained faithful to respondent perceptions and perspectives.

Theoretical Memoing

Theoretical memoing occurred throughout the transcription and coding phase of data analysis. Groenewald (2008) states 'memoing is the act of recording reflective notes about what the researcher (fieldworker, data coder, and/or analyst) is learning from the data'. During coding the researcher pauses to capture a thought or reflection regarding what they have just read. (Glaser 1978, p. 83) describes memoing as the 'bedrock of theory generation'. Groenewald (2008) adds that memos increase the credibility of qualitative research as they provide additional insight into the data. Using the Notes application on the researcher's personal computer, a note was created during the open coding of each transcript. In this note, memos were recorded during the coding phase which often highlighted respondent physical behaviours and verbal tone which are unidentifiable in the coded transcript.

Open Coding Using NVivo-12

All transcripts were then uploaded into NVivo-12 for in-depth open coding to occur. Laimputtong and Ezzy (2005, p. 199) suggest this second stage of open coding should involve subsequent readings where the 'researcher attempts to develop concepts and codes on a higher level of abstraction'. Table 2 illustrates one example of this process.

Table 2 Open Coding Sample 1 (source: Author)

Raw Data – Interview 12	**Open Codes**
I probably think like, I guess it's maybe like more education cause I think it would be nice to kind of talk about the cultural heritage at orientation. Yeah. Um, cause I knew about it already a little bit. Um, cause I've researched RPA and yeah, before I got the job, when I went for my interview, it's important to know the history of the Hospital. But I feel like when you're coming in for orientation I was just thinking if you're like a new grad nurse, it would be good to hear a bit about or know a bit about the history. Um, I don't know how you would include that in the orientation but having something included would be good. Yeah, I think it would be good.	Supports increased education Suggests utilising orientation Underwent prior historical research Important to know hospital history New starters devoid of knowledge

A node (NVivo name for code) folder was developed to individually cluster each interview and focus group question. This enabled the efficient recall and cross-analysis of complete question responses. A second node folder was created where significant quotes could be dropped and stored for further investigation and later use. Cases were developed for each transcript to enable the categorisation of each respondent via number of years employed and their gender, again for further investigation and cross-analysis during the data analysis process. Initial parent nodes were created and built on throughout the coding process. As new codes appeared the NVivo node list was expanded. All nodes start as 'parent' nodes but though a reflexive and iterative process of constant comparison and examination can shift to become a 'child' node (secondary sub-node). As new nodes are developed that resemble the early development of a theme or core category, a new parent node is developed within which child nodes are then grouped.

Figure 31 below is a screen shot taken from NVivo-12 illustrating both parent and child nodes. The Cultural Heritage Disconnection parent node contained 30 associated child nodes. There were 129 references associated to these child nodes. All nodes that begin in lower case are in vivo nodes. At the conclusion of transcript analysis 45 parent nodes and 241 child nodes had been created.

Name	Files	Referen...
cbh infrastructure confusing wayfinding	3	5
CH Disconnection	0	0
Accessibility fosters engagement	7	11
Departmental CH not promoted	7	9
desensitized	5	6
Disregard for heritage	3	4
Embarressment over lack of connection	2	2
Feel almost stupid	1	1
generational thing	2	5
Haven't had a chance	1	1
Historical information suppy poor	2	2
I don't know if that applies to me - in vivo	1	1
Increase communication quality	2	2
Info. type influences engagement	1	1
Information overload cause disengagement	1	1
Institutional connections	2	2
Knoweldge promotes engagement	3	7
Knowledge awareness through training	1	1
Lacking historical knowledge	7	15
Lacking organisational knowledge	5	9
Lacking personal connection to rpa	2	3
Limited technological engagement	1	3
Mode of accessability fosters disengagment	1	1
New starters devoid of knowledge	4	6
Not motivated enough to visit	2	2
Outsider feelings	1	1
Primary purpose of a building	3	4
Primary purpose of employment	3	3
Surface level analysis of heritage	2	3
Sydney university connection	6	7
Time poor unmotivated	5	10
Unmotivated towards some communication mediums	4	6

Figure 31 NVivo Coding Sample 1 (source: Author)

Axial Coding - Cleaning up the Data in NVivo-12

At this stage in the research the NVivo project file was duplicated (NVivo project 2) in preparation for axial coding and major editing. All nodes and their associated reference files were then individually revisited to explore accuracy and clarity. Nodes containing only one reference file were merged with other 'like' nodes. Nodes that displayed similar characteristics were either merged or relabelled with a more appropriate naming reference. For example, the parent node Cultural Heritage Disconnection contains the child nodes of 'haven't had a chance', 'Time poor/ unmotivated' and 'Not motivated enough to visit'. Using the 'Aggregation' feature in NVivo-12, the child nodes of 'haven't had a chance' and 'Not motivated enough to visit' were merged with 'Time poor/unmotivated' as they reflect similar notions. This exercise continued until all parent and child nodes reflected different concepts or ideas. Relationships between nodes where then identified and nodes were grouped relative to each other form loose categories (see Figure 32).

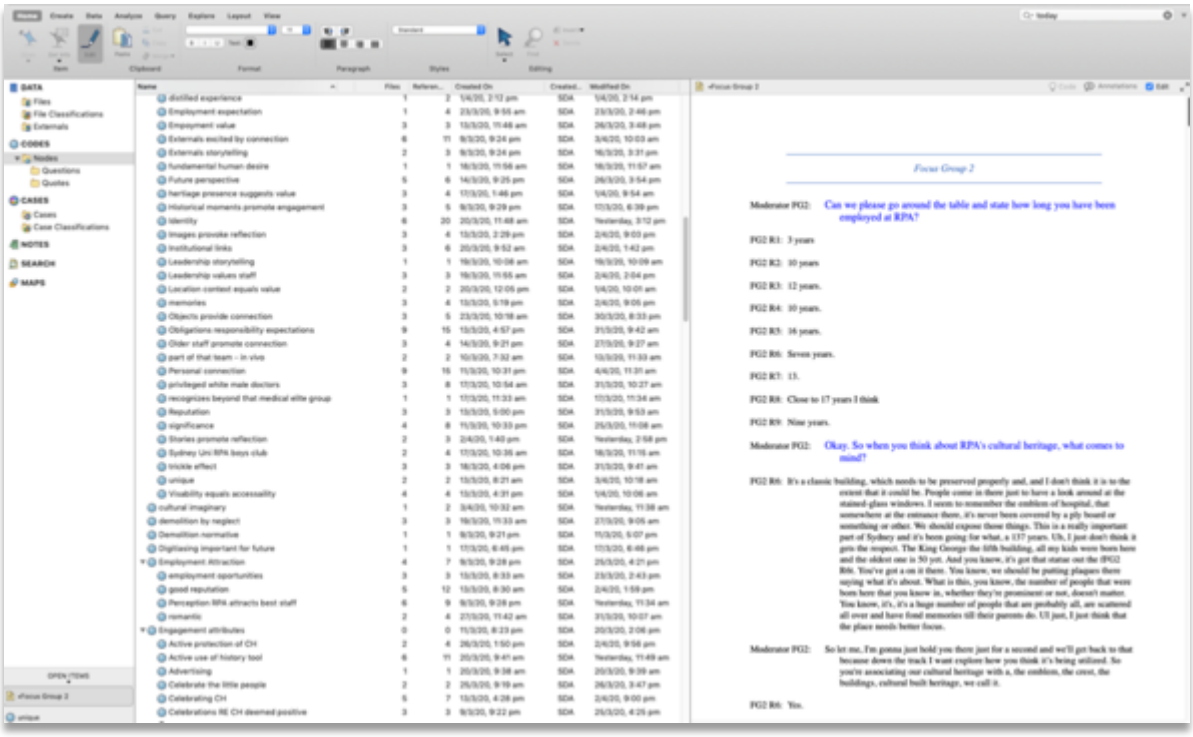


Figure 32 NVivo Coding Sample 2 (source: Author)

Selective Coding Using NVivo-12

Upon completion of cleaning the data in NVivo-12, selective or focussed coding took place. The aim of focussed coding is to progress towards discovering emergent themes or categories. Focussed coding is described by Charmaz (2006, p. 57) as a more 'directed, selective and conceptual' process than open coding and occurs by grouping the various codes (nodes) into larger categories (parent nodes) in an effort to shape core categories and theory. Glaser (2005, p. 4) suggests a researcher should deliberately search out core categories when coding data but notes that 'categories tend to emerge quickly, giving the appearance of finding core categories. But the analyst should be suspect of these as core. It takes time and much coding and analysis to verify a core category through saturation, relevance, and workability.'

Due to the unique 'insider' perspective of the researcher, coding was an iterative and reflexive process moving from open to selective and back again. The constant comparison of the 45 parent and 241 child nodes saw nodes reviewed and changed to reflect more accurate groupings within their parent node groups. Duplicate or similar concepts and notions that could be further clustered under a more selective common naming node were shuffled accordingly. Table 3 provides one

example illustrating how selective coding theoretically occurred. Raw transcript data was open coded to produce the key concepts: historical reminder, physical representations, and active physical engagement.

Table 3 Selective Coding Sample (source: Author)

Raw Data – Interview 12	**Open Codes**	**Selective Codes**
Yeah, like I guess I walk from building 12 past King George building and then across and every time I walk past the statue that's in front of King George V and I'm reminded that this hospital has such a strong cultural heritage. And then as you walk in, again, there's more statues as the paintings, you know in there there's a head or the bust as you walk in. And then, you know, as you further walk in, they've got some displays on the right. And I often go over and have a look and see what's there. So I feel like as you walk through and as my journey into the ward, I'm reminded of the cultural heritage. Yeah. Yeah. So I guess that's kind of how I ...	Physical engagement Historical reminder Physical representations Physical representations Repetition of representations Physical representations Active physical engagement Historical reminder Organisational engagement point	Organisational connection context Engagement context Active member engagement

Selective coding led to the emergence of 16 parent nodes or categories, and 273 child nodes or sub-categories. These are detailed in Figure 33.

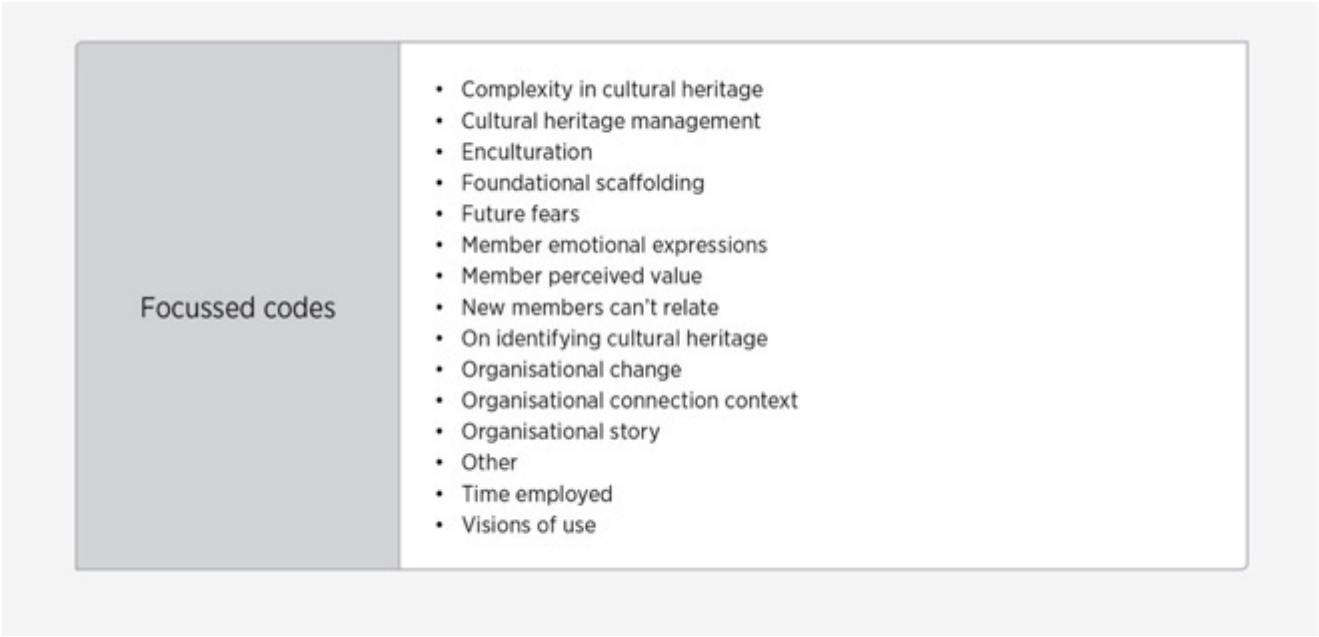


Figure 33 Focussed Coding (source: Author)

Node Saturation in NVivo-12

Due to the researcher insider role, data saturation was largely identified before the completion of transcript coding. Bazeley and Jackson (2013, p. 82) suggest 'a priori, or theoretically derived codes' stem from undergoing the literature review and from pre-existing theoretical understandings surrounding the topic. Urquhart (2013, p. 24) explains that 'the point at which selective coding occurs is fairly obvious, as there are no new open codes suggesting themselves and definite themes are emerging … some grouping of categories can take place at this stage and this helps develop the abstraction of the theory'. During coding of the tenth interview transcript, it became apparent that no new codes were emerging. Additional transcript data provided only occasional code variants or resulted in the renaming and refinement of existing codes. At this point the selective coding phase of data analysis commenced.

During the selective coding phase of transcript analysis parent nodes were identified and child nodes allocated where sub-themes and concepts emerged. Although several perspectives can be associated with each line or phrase of text, by keeping the thesis question visually at hand, and constantly referring to the key words of 'value' and 'perception', coding and node creating became

targeted and precise. That said, the researcher was mindful of confining their thinking and made every effort to remain open to the data, and to recognise and explore unforeseen concepts that emerged.

Theoretical Coding and Building Core Categories

Core categories represent the main concepts that emerge at the conclusion of focussed coding and occur as a result of the clustering of sub-categories to form a main theme. They provide the building blocks for the final substantive theory. The core category is selected 'when the researcher can trace connections between a frequently occurring variable and all of the other categories, sub-categories and their properties and dimensions' (Birks & Mills 2015, p. 98). When open coding fractures the data, selective coding reconnects the data in ways that extend beyond thematic analysis, and the mere reporting of observations. The data is then critically analysed. This process provides a methodological rigour that offers integrity to the research.

In the same way that open codes were compared, analysed and merged under broader conceptual codes to constitute a selective code, selective codes where compared and contrasted to discover how they related in order to build categories. For example, the focussed codes *On Identifying Cultural Heritage* and *Organisational Story* were incorporated into the category *Engagement Context. Visions of Use* and *Future Fears* informed the new node of *Capacity for Use* that was then merged into *Management Complexity.*

Three main core categories with their associated sub-categories remained at the conclusion of selective coding: *Organisational Value, Member Value and Management Complexities* (see Figure 34). The first core category of *Organisational Value* contained two parent nodes and 128 child nodes. The second core category of *Member Value* contained three parent nodes and 107 child nodes (see Figure 35). The third and final core category of *Management Complexities* contained two parent nodes and 35 child nodes.

Core categories	**Organisational value** • Engagement context • Existence benefits **Member value** • Engagement benefits • Engagement challenges • Indentification, collection and preservation behaviours **Management complexities** • Financial implications • Operational challenges

Figure 34 Core Categories (source: Author)

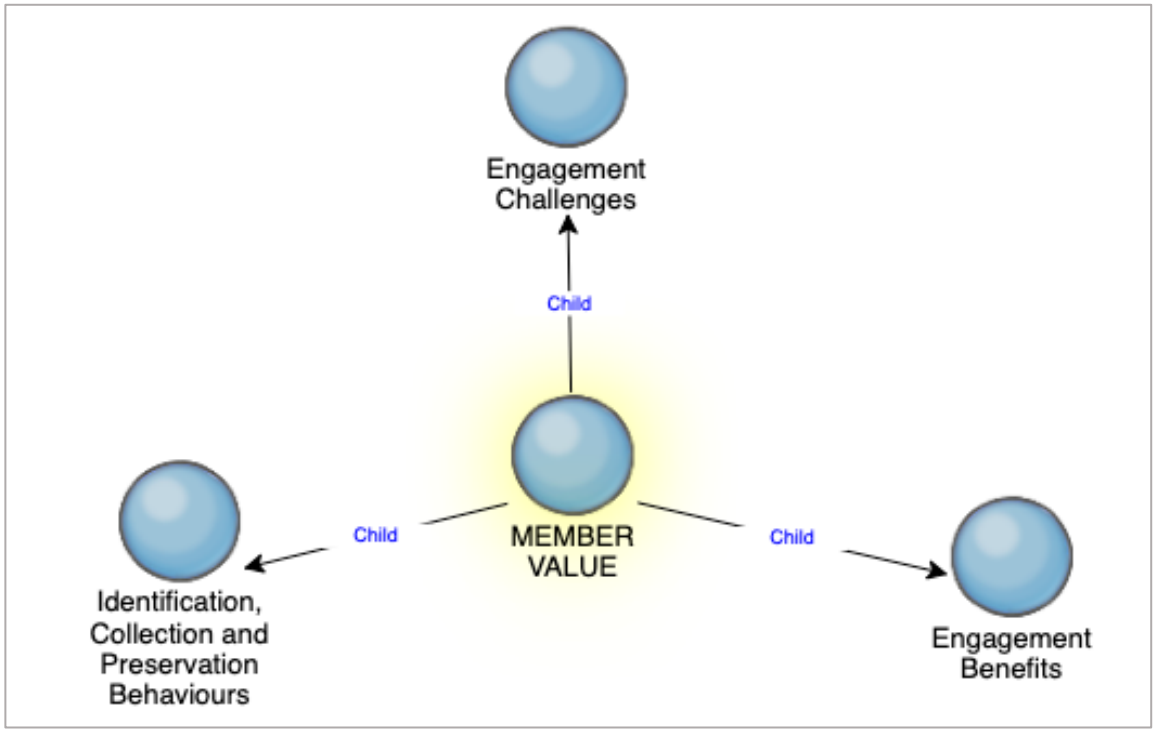


Figure 35 NVivo Diagram Example of Core Theme Member Value (source: Author)

Conclusion

This chapter presented a discussion of the methodological rationale underpinning the method of inquiry adopted in this thesis, and outlined the stages involved during the data collection process.

Due to the researcher insider perspective, and unique positioning and relationship to the organisation, principles of grounded theory and an interpretivist approach were explained and justified as frameworks for the study. Ethical considerations including participant and data confidentiality and security were discussed. As the phenomenon of interest in this study are the perceptions and perspectives of organisational members, the use of cultural probes was also introduced and justified. Cultural probes helped instigate participant engagement and further response rates before and during interview and focus group sessions. Data management and data analysis was also explained and explored. Several stages occurred during data analysis including interview transcription, rough, open, axial, and selective coding, and theoretical coding utilising computer software, which were all explored and explained. Theoretical coding and the construction of core categories led to the development of three core themes: Organisational Value, Member Value and Organisational Heritage Risk.

Chapter 4, which follows, will present the empirical findings of this study and the conceptual emergence of the substantive theory.

Chapter Five: Research Findings

Introduction

This chapter begins by revisiting the primary thesis question and briefly reiterates the conceptual process used during data coding.

What is the meaning and value of organisational cultural heritage to Royal Prince Alfred Hospital?

In order to answer this question, the chapter will then outline, how, over the course of writing the thesis, the data and stories from the transcripts of the 32 participants involved in the study were constantly categorised, reviewed, recategorised, and sorted into themes in the section titled **Working with the Data: Child nodes, sub-categories and core categories**. These findings will then be explored in the section titled **Voices of the Participants: Working with, understanding, and analysing the data**.

Firstly, the core category of **Exploring Member Value,** that is, what the participants spoke about as their experiences, views, and perceptions of cultural heritage at RPA is explored under the subheadings of **Identification, Preservation and Collections Behaviours,** the contexts in which these occur, **Engagement Contexts**, and the benefits of heritage, **Existence Benefits.**

Secondly, **Exploring Organisational Value** will look at the value to RPA of cultural heritage including the **Engagement Contexts** and **Engagement Benefits** of heritage as experienced by study participants.

Thirdly, **Exploring Management Complexities**, looks at the issues, the difficulties, and the potential for change, through the lens of financial constraints, neo liberalism (**Financial Implications**), and the **Operational Challenges**, and the ways to meet these challenges.

Working with the Data: Child nodes, sub-categories and core categories

This section builds on the outline provided in the methodology exploring in more depth, the critical, dynamic, and complex process that was undertaken to analyse and interpret the stories, as documented in the transcripts of the 32 study participants. Figure 36 illustrates the four conceptual levels that occurred during data analysis. Participant quotes, extracted from the transcripts in their

own words, are individually analysed and interpreted. Table 1 should be referred to for respondent contextualisation surrounding department/role employed, years employed and gender.

As outlined previously, this research project utilised a perspective-based methodology derived from grounded theory. Glaser (2005, p. 2) suggests that when exploring the data, the researcher raises 'perspectives to the abstract level of conceptualisation hoping to see the underlying or latent pattern, another perspective'. Bazeley and Jackson (2013, p. 261) add that when developing theory from research data the researcher should aim to 'specify patterns and relationships between concepts [or themes]'. Themes are then related to one another through thematic analysis in order to build substantive theory, and 'should display multiple perspectives from individuals and be supported by diverse quotations and specific evidence' (Creswell 2014, p. 200). Researchers should target quotes 'to illustrate such features as: the strength of opinion or belief; similarities between respondents; differences between respondents; [and] the breadth of ideas' (Hancock 2002, p. 23).

Through exploring respondent ideas and perceptions, this chapter exposes several concepts and themes illustrating diverse and sometimes contested interpretations of the meaning and value of RPA heritage.

Figure 36 Substantive Themes Conceptual Levels (source: Author)

Sub-categories, Core categories and Substantive Themes

Upon completion of transcript coding seven key sub-categories were identified from within the data including **Engagement Benefits**, **Engagement Challenges**, **Engagement Context**, **Existence Benefits**, **Identification, Collection and Preservation Behaviours**, **Financial Implications** and **Operational Challenges.** These sub-categories were further interpreted and grouped as three major core categories or substantive themes (see Figure 37 and Table 4).

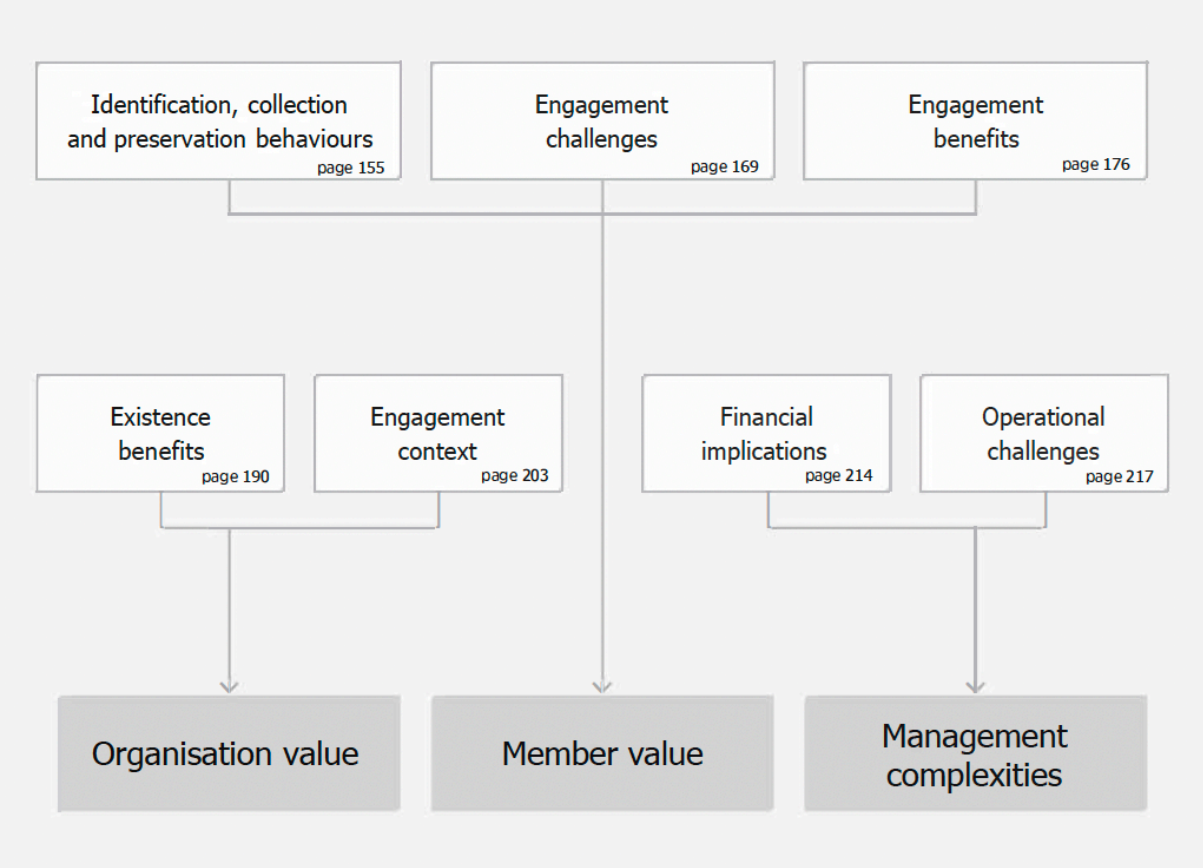


Figure 37 Substantive Themes and Sub-categories (source: Author)

The core categories that participants spoke of regarding organisational cultural heritage at RPA were categorised as **Organisational Value**, a **Member Value** or as **Management Complexities**. What follows is an exploration of these themes and their sub-categories. Each theme is explored and supported by interview and focus group respondent data as presented in the words of the participants. Due to the complex and interrelated nature of respondent feedback many sub-categories and themes intersect and are often repeated which is to be expected when exploring

complex types of heritage, uses of heritage and interpretations in purpose, meaning and value of heritage.

Each core category, including the number of transcript references, the number of child nodes identified, and the number of sub-categories were identified (see Table 4). A transcript reference refers to the total number of times a respondent discussed a topic or concept that would be merged under a child node. It was noted that Organisational Value contained the highest number of transcript references, closely followed by Member Value, with Management Complexities viewed as less significant by study respondents. See Figures 15 and 16 for a further visual summary of these results. This suggests that study participant responses centred around themes more aligned to organisational value than individual member value.

Table 4 Core Categories Table (source: Author)

Core Categories	**Organisational Value**	**Member Value**	**Management Complexities**
Transcript references	405	358	152
Child nodes	123	102	35
Sub-categories	Existence Benefits Engagement Context	Identification, Preservation and Collection Behaviours Engagement Challenges Engagement Benefits	Financial Implications Operational Challenges

The next breakdown (see Table 5) provides the definitions for each sub-category and core category illustrating the progression and rationale behind the development of the core category and substantive themes.

Table 5 Sub-categories and Core Categories Definition Table (source: Author)

Sub-category	Definition	Core Category	Definition
Existence Benefits	Encapsulates those aspects of cultural heritage that underpin and strengthen RPA as an organisation as perceived by respondents.	**Organisational Value**	Encapsulates the various ways in which respondents identified engaging with heritage at RPA, and the perceived benefits in the presence of heritage to the organisation.
Engagement Context	Encapsulates those ways in which respondents described interacting and engaging with heritage at RPA.		
Identification, Preservation and Collection Behaviours	Encapsulates respondent behaviours surrounding the identification and preservation of heritage, and their interpretations of that heritage.	**Member Value**	Encapsulates the organisational member identification, interpretation and value of RPA heritage as perceived by respondents.
Engagement Challenges	Encapsulates methods and modes of staff engagement with organisational cultural heritage and the associated issues surrounding engagement as identified by respondents.		
Engagement Benefits	Encapsulates the positive outcomes associated with or derived from organisational member contact with RPA cultural heritage as perceived by study respondents.		
Financial Implications	Encapsulates the monetary issues associated with the continued storage, preservation, maintenance, and refurbishment of organisational cultural heritage as perceived by respondents.	**Management Complexities**	Encapsulates the numerous operational challenges and financial complexities faced by the organisation due to the presence and use of heritage at RPA.
Operational Challenges	Encapsulates the numerous challenges surrounding the management of organisational cultural heritage, the operational challenges it represents and the impact it has on the primary goals of the organisation.		

Existence Benefits and **Engagement Context** example child-nodes can be seen in Table 6. These child nodes reflect the key concepts that emerged which demonstrate the varied ways in which organisational members perceive RPA heritage to offer value to the organisation.

Table 6 Organisational Value Sub-category Child Nodes (source: Author)

Existence Benefits	Engagement Contexts
Calming quality	Family stories
Credibility	Displays
Reputation	Museum
Longevity priceless	Staff stories
Permanence	Management communications
Symbolic	Wall historic timelines
Tradition	Departmental heritage stored
Employment expectation	Individual preservation

Identification, Preservation and Collection, **Engagement Challenges** and **Engagement Benefits** child-nodes examples can be seen in Table 7. These themes reflect the varying member views surrounding the identification and preservation of material heritage, the positive outcomes that resulted from interacting with heritage, and the issues encountered surrounding interaction.

Table 7 Member Value Sub-category Child Nodes (source: Author)

Identification, Preservation and Collection Behaviours	Engagement Benefits	Engagement Challenges
Hierarchy	Conservation starter	Lack of connection
Emblems and insignias	Sense of belonging	Time poor
Old buildings	Pride	Unmotivated
Old boys club	Gravitas	Primary purpose of employment
Rare means heritage	Powerful response	Transient staff
Innovation	Engagement motivator	Visibility
Skewed representation	Behaviour influence	Outsider feelings
Selective heritage	Connections to people	New staff

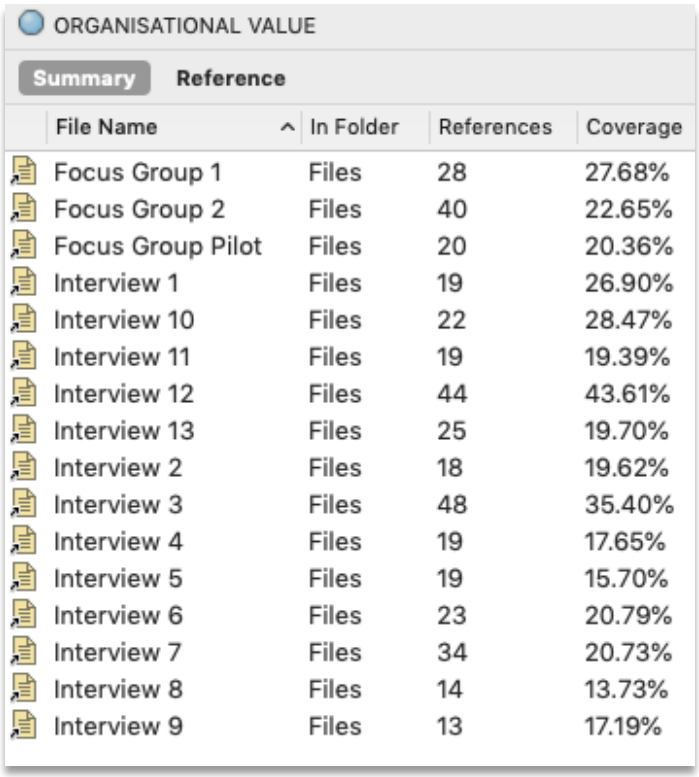
Financial Implication and Operational Challenges example child-nodes can be seen in Table 8. These themes reflect the complex issues associated with the presence of heritage in a healthcare setting.

While this theme could have been encapsulated within other categories, it was decided there was enough data to warrant a separate core category and discussion.

Table 8 Management Complexities Sub-category Child Nodes (source: Author)

Financial Implications	Operational Challenges
Down to money	Space management
Revenue	Fit for purpose
Draw the line	Practicalities and priorities
Responsibility	Future perspective
Storage	Compromise
Primary purpose	Demolition by neglect
Restoration costs	Location equals value
Repairs and waste	Organisational change

The NVivo-12 node summary feature was utilised to further analyse the collected data. The Organisational Value core category indicated below in Figure 38 illustrates in the coverage column that Organisational Value themes were discussed between 13.73% and 43.61% of the time in interview and focus group sessions. This is a significant range variance demonstrating that not all respondents viewed organisational value in RPA heritage. On average, Organisational Value themes were discussed 22.98% of the time during interview and focus group sessions, and therefore constitute 22.98% of all references across interview and focus group sessions.



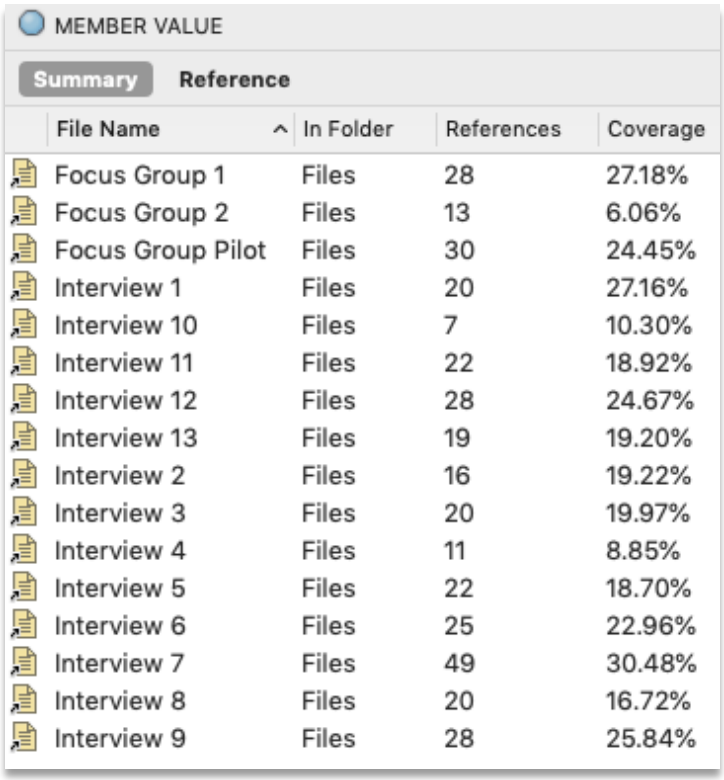
ORGANISATIONAL VALUE

Summary | Reference

File Name	In Folder	References	Coverage
Focus Group 1	Files	28	27.68%
Focus Group 2	Files	40	22.65%
Focus Group Pilot	Files	20	20.36%
Interview 1	Files	19	26.90%
Interview 10	Files	22	28.47%
Interview 11	Files	19	19.39%
Interview 12	Files	44	43.61%
Interview 13	Files	25	19.70%
Interview 2	Files	18	19.62%
Interview 3	Files	48	35.40%
Interview 4	Files	19	17.65%
Interview 5	Files	19	15.70%
Interview 6	Files	23	20.79%
Interview 7	Files	34	20.73%
Interview 8	Files	14	13.73%
Interview 9	Files	13	17.19%

Figure 38 NVivo-12 Organisational Value Node Summary (source: Author)

The Member Value core category indicated below in Figure 39 illustrates that Member Value themes were discussed between 6.06% and 30.48% of the time in interview and focus group sessions. This also demonstrates a significant range variance again highlighting that not all respondents viewed heritage as offering member value. On average, Member Value themes were discussed 20.04% of the time during interview and focus group sessions and therefore constitute 20.04% of all references across interview and focus group sessions.



File Name	In Folder	References	Coverage
Focus Group 1	Files	28	27.18%
Focus Group 2	Files	13	6.06%
Focus Group Pilot	Files	30	24.45%
Interview 1	Files	20	27.16%
Interview 10	Files	7	10.30%
Interview 11	Files	22	18.92%
Interview 12	Files	28	24.67%
Interview 13	Files	19	19.20%
Interview 2	Files	16	19.22%
Interview 3	Files	20	19.97%
Interview 4	Files	11	8.85%
Interview 5	Files	22	18.70%
Interview 6	Files	25	22.96%
Interview 7	Files	49	30.48%
Interview 8	Files	20	16.72%
Interview 9	Files	28	25.84%

Figure 39 NVivo-12 Member Value Node Summary (source: Author)

The Management Complexities core category indicated below in Figure 40 illustrates that Management Complexities themes were discussed between 1.38% and 20.12% of the time in interview and focus group sessions. On average, Management Complexities themes were discussed 10.27% of the time during interview and focus group sessions, and therefore constitute 10.27% of all references across interview and focus group sessions.

MANAGEMENT COMPLEXITIES

Summary | Reference

File Name	In Folder	References	Coverage
Focus Group 1	Files	13	13.92%
Focus Group 2	Files	16	15.19%
Focus Group Pilot	Files	11	14.53%
Interview 1	Files	12	17.52%
Interview 10	Files	4	4.78%
Interview 11	Files	2	1.46%
Interview 12	Files	2	1.38%
Interview 13	Files	19	20.12%
Interview 2	Files	6	3.97%
Interview 3	Files	18	14.83%
Interview 4	Files	6	9.90%
Interview 5	Files	9	8.86%
Interview 6	Files	14	23.15%
Interview 7	Files	8	3.46%
Interview 8	Files	4	3.31%
Interview 9	Files	8	7.95%

Figure 40 NVivo-12 Management Complexities Node Summary (source: Author)

Figures 38-40 demonstrate and highlight the contested nature and wide range of perspectives and views surrounding the cultural heritage of RPA Hospital. Not all study respondents perceive heritage and heritage value in the same way. As example, Interview Respondent 13 referred more to the Management Complexities associated with heritage than value to them or the organisation. Interview Respondent 11 however saw minimal issues surrounding this theme.

The Voices of the Participants: Working with, understanding, and analysing the data

This section is the core of this thesis. The data collected from the interviews and the focus groups, was rich and detailed. The participants were generous in sharing their time, experiences, ideas, hopes, dreams, and possibilities. It is these stories that form the basis of this thesis.

Exploring Member Value

This section explores the 32 participants ideas about the value, to them, of cultural heritage at RPA. It is divided into the following as illustrated in Figure 41:

(1) Identification, Collection and Preservation Behaviours

(2) Engagement Benefits

(3) Engagement Challenges

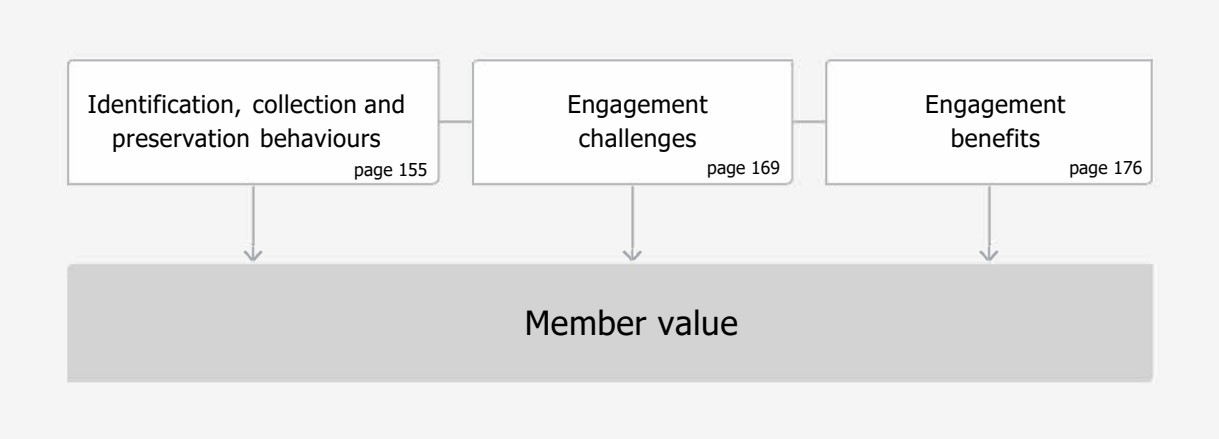


Figure 41 Member Value Sub-categories (source: Author)

Identification, Collection and Preservation Behaviours

The sub-category of Identification, Collection and Preservation Behaviours was primarily viewed as contributing to organisational member value and so was merged into the core category of Member Value. RPA staff members and volunteers offered several views and key notions surrounding these concepts. Child nodes that constitute this category included themes such as hierarchy, emblems and insignias, old buildings, old boys club, subjective heritage value, skewed, selective preservation, staff as heritage, innovation, and rare means cultural heritage as examples. In exploring the meaning and value of cultural heritage, a clear definition and understanding proved fluid, varied and sometimes contentious, as did the processes of identifying heritage objects or objects worthy of preservation.

Staff members identified both material and non-material dimensions of cultural heritage. Material heritage identified, included the campus buildings and architecture, medical artifacts, and staff members; and non-material heritage included the organisational traditions, behaviours, and stories.

Interview Respondent 1 identified both material and non-material heritage. They suggested the physical reminders including material built heritage and varying movable artifacts, offer not only surface level manifestations of value, but also connect to deeper member values and beliefs. Further, that material heritage offers those physical reminders that support personal and organisational beliefs and values that underpin organisational and personal memories associated with the Hospital. Values and the framing of memories are also cited as being momentary and relational to the current hospital or departmental environment. They serve a purpose and are driven by both emotions and needs experienced by and relevant to the individual staff member at the time of interpretation and assessment. This suggests there can be a strong emotive response to heritage at the Hospital.

> **IR1:** *I think it's probably both. I think it's the **physical reminders**, and they're often driven by our **beliefs** of what we need at the time. But then it's that ongoing behaviour of **beliefs and values**, and more of those more intangible components of cultural heritage, the **memories.** These are the things that constitute cultural heritage in my mind.*

This suggests there can be a strong emotive response to the heritage at the Hospital that constitute the ways people think about cultural heritage.

Organisational behaviours such as innovation, progression and pioneering developments were noted as organisational heritage. These underpin the image and identity of the organisation and as such attract staff towards employment at the Hospital. Reputation, status, and prestige are built and supported through the continued efforts of staff and the organisation to be leaders in the field of healthcare.

> **IR6:** *The other of course is and I've just alluded to it, is **innovation**. So, you know, the world leading research that's been happening here, you know, over 135 years, well probably 150 years to be honest, with relationships with the university.*

PFG R1: *Well I think it's the people as well. But, for me RPA's cultural heritage is about* ***progression and innovation*** *too.*

PFG R3: *Yep.*

PFG R1: *And if you look at what RPA was doing in the early stages, they were doing stuff well before, but you know they really did lead the way. It was a* ***pioneering*** *hospital.*

PFG R4: *Yeah, they did they* ***pioneered*** *a lot of procedures, and that was, that was one of the reasons it* ***attracted*** *me to it cause it had, they were the first to do a number of things…*

PFG R1: *Heart transplant.*

PFG R4: *That's right.*

PFG R3: *Liver transplants.*

PFG R4: *Yeah that was really attractive for me to start working here because we do break ground on things and have that history of doing that.*

Several organisational members also viewed collection and preservation as an important aspect in preserving organisational knowledge and memory. It was felt this memory is in part held by RPA staff members and as such viewed organisational members as a part of the organisational heritage.

Interview Respondent 1 noted the importance of their personal corporate memory, and the loss of memory when long-serving staff members leave the organisation.

IR1: *Yes, I've been here since 1994, so that's a long stay, so I do have the* ***corporate memory*** *of a lot of things that have come and gone even in that time. How do we possibly remember what our heritage is if we don't have records like this [indicating the register], because once individuals go then all of that corporate memory goes as well … And then the only way we can actually remember our heritage, which I think often influences decisions about where we have headed in direction, is when we've got these kinds of* ***records****.*

IR5: *Margaret Pike for example … there are those kinds of almost* ***dynasties*** *that are within staff that aren't necessarily in the medical ranks like a Horvath. I think Diana Horvath [ex Chief Executive] and her daughter, Lisa, I think is an oncologist here. So, there are those kinds of dynasties in inverted commas of the professional staff and then also the support staff, and I think they're part of the cultural heritage … for me in a way it's that* ***long association****. I'll never be in the museum here [laughs], but I kind of think I'm part of the cultural heritage and other staff members I've known that have been here greater than 26 years …*

Material records help capture organisational and corporate memory and as such are important stores of non-material heritage and should be actively captured.

Organisational stories also constitute a significant component of personal memory. Particularly those origin stories attached to the foundation of the Hospital that have become a part of the myth and legend of the organisation.

> **IR13:** *That makes something part of our cultural heritage, the **stories** I suppose around it. So, you know, it starts from why this hospital was built for who, by who. So, the story of him being shot and then being embarrassed, etc., etc. The community, putting money together, etc., etc. **Building** it all from that and that story carrying on in the buildings, carrying on in the **people** who work in the buildings that tell **new staff** that pass it on as the next thing. And you've heard **iterations** of that story as it goes on…*

Interview Respondent 13 noted the foundation story as the platform from which all heritage at the Hospital is centred around and derived from. The values established with that story are carried with the built heritage of the Hospital and with the staff members that perpetuate those beliefs and values which inform and frame beliefs and behaviours of new staff members.

Respondent 8 similarly supported these notions identifying the non-material dimensions of heritage including organisational traditions and memories however noted organisational hierarchy as a central component of heritage. Traditions including behaviours and beliefs are passed down through the organisation via its members. These traditions are underpinned by hierarchies that offer both benefits and burdens to organisational members and the organisation.

> **IR8:** *I think about the **traditions**, all the traditions that have come before working here. And yeah, probably more the historical aspects of working in a place like this. So that's sort of what I would think it is, and the traditions that have come through, I guess to us where there is still, you know, there's still that **medical hierarchy and nursing hierarchy** and so on. So, I think that we still have a lot of that – more so than other hospitals, I would think.*

Given that hospital management has traditionally been dominated by men in senior positions of management the stories that have been written and preserved are those stories of these powerful men.

> **IR1:** *Health is a **hierarchy**, and the **doctors** are at the top and the **cleaners** are down the bottom and there's a whole gradient in between kind of thing. So, I think this is one of the really enormous **challenges** that we're facing with our history in a much broader context.*

> **IR7:** *Definitely. Yep. But not even just the staff, more the way the place is managed or the way that the organisation is set up or **hierarchy** of things. The org chart, any of that.*

The stories and the preservation of heritage artifacts has been a selective process based on who managed the Hospital and who curated the museum, and what was deemed important at that time. The first stories to be recorded were those of powerful men. Organisational memory has been selectively preserved to reflect those departments and organisational members aligned with hospital governance and the medical profession. The memorialisation of late 19th and early 20th century figures through art commissions like marble busts, stained glass windows, bronze plaque reliefs and paintings focussed on educated male doctors, wealthy benefactors, and board members. Other collected heritage material included administrative board minutes and committee meetings.

Other stories, such as the stories of nurses and nursing, came to be celebrated later. Nursing was not viewed as a serious profession until the mid-1930s when training changed to include eight weeks of preliminary training before graduates entered a four-year training course. It was not until 1986 that nurse training moved from hospital-based training to become university delivered. The RPA Museum was originally established as a Nursing Museum and so has a collection heavily biased towards the nursing profession. This may have occurred as a direct response to an organisation that favoured and supported men, and more specifically, male doctors. The University of Sydney Medical School had proudly preserved its medical student history. Nurses trained at RPA were not supported or esteemed in the same way, and so sought their own avenue to celebrate and commemorate their life and profession.

> **IR7:** *That very core set off generally **privileged white male doctors** who are all **trained together**. That then affects the, the overall **image** I suppose, of the institution. I imagine there are certain things which are more **treasured** or would be more cared for based on that*

*very **hierarchical** doctor is king. Not so much anymore, but I imagine those sorts of things are what was treasured and that's what has **survived** more than your sort of more everyday stuff … now still there is gender bias, even if it's not deliberate, you can see that. It says okay well this is where the organisation is coming from. But it's not a **balanced** discussion.*

Interview Respondent 1 felt the present use of storytelling and heritage is unevenly weighted, misrepresenting the wider organisation. This may reflect the value placed on non-medical areas of the organisation.

> **IR1:** *I think that it has probably existed from time immemorial, and it continues to be the challenge today. And I can tell you now because I have managed corporate support staff, they know they are down that ladder when it comes to the **hierarchy**, they know it full well. So, we can talk all we want about core values, blah blah blah, blah blah. But they know they are down the bottom of the heap and everything about our organisation **enforces** that on a daily basis, from how they're spoken to, to how they are given priority around recruitment. Particularly some of that **storytelling** around our heritage of the areas that they've worked in as well. Some are more **valued** than others, and that's **reflected** in the heritage that has been **captured**.*

Organisational hierarchies are weighted with outdated socio-cultural beliefs and behaviours that have emerged from both socially elitist and male oriented frameworks. It was noted that collection and preservation have in the past been selective and that what was chosen and represented does not necessarily reflect the wider organisational history. Interview Respondent 7 noted the skewed nature of the Hospital's heritage collection being derived from the wealthy white male perspective. This is both indicative of the late Victorian era and early to middle 20th century society and health care.

> **IR7:** *I think there has probably been a tendency also to focus from a historical point of view, to focus on the boy's club because they would've been the people in the headlines, they're the names, that's what buildings are named after, what rooms are named after, what scholarships are named after, and institutes …. And It would give quite a **skewed view** if you looked back at say the history of the first 50 years of RPA, it would be full of **old white men**. … So, you've got this vision, this impression of RPA as this big **grand sandstone place**, run by a very **select elite intelligent** group of people, but not the whole story, but we might not have anything, any tangible or physical records of that ... So, it does give you a **skewed look**,*

I think … So, I think that very much gives you a, umm, there's no buildings or lecture theatres named after women. And is that because there's no women, no, because women didn't historically have a huge impact here, but maybe it's not recorded, or it's ***not valued*** *or historically it hasn't been. I guess what I'm trying to say is that there was more to this place than that, but that's probably what's been preserved and focussed on and documented and that's completely understandable.*

Interview Respondent 7, a female executive, noted that other figures and voices from the Hospital's heritage are not present, and as a result feels personally excluded from the historic narrative. Women dominated many positions across the Hospital within the kitchens, laundry, sterilisation departments and nursing. This focus on white men reflects the nature of 19th and 20th century healthcare and accept this as an undeniable reality of the time. Many collected objects have been preserved due to historic associative value in that they are deemed historic because of their connection to figures of prominence. Objects associated with the laundry or kitchen services such as sewing repair kits, or food preparation implements would have been considered mundane and of no historic value, unlike a World War Two nursing war pin, of which the museum displays several collections and are therefore considered of high value. Interview Respondent 7 questioned the reasoning behind this which suggests they perceived the use value of Hospital heritage to be more important than associative value. They again highlight the hierarchical nature of the Hospital, and the elite status of the doctor as influencing perceived value and collecting behaviours.

IR7: *I imagine that if you know Anderson Stewart[1] had a beautiful gold-plated ballpoint pen, that probably would be a* ***valued object****, but what's to say that's more* ***important*** *than these, two-cent ballpoint pens. They'd probably do a shit load more work, sorry. They do a lot more work than Anderson Stewart's notebooks probably did. But were the records of the physio kept or were the records of the front desk clerk kept, like those records are probably just as important and can tell you just as much, even more. But I imagine there are certain things which are more* ***treasured*** *or would care very much based on that very* ***hierarchical doctor is king****. Not so much anymore, but I imagine those sorts of things are what was treasured and that's what has* ***survived*** *more than your sort of more everyday stuff.*

[1] Sir Thomas Anderson Stewart was the founder of the University of Sydney Medical School, would serve as Dean of the Faculty of Medicine and Chairman of the Board of Directors of RPA (Epps 1922).

Respondents from the pilot focus group further noted the white patriarchal nature of the Hospital heritage collection, however attributed blame to the nature of society at the time. The unequal division of power across the Hospital's services and management significantly guided the collection of material objects held by the Hospital.

> **PFG R1:** *It comes back to that again, you know, that **white patriarchal** society, and that RPA, like many places, it's not unique, they all would have been like that.*

Interview Respondent 1 adds that the organisational memory and story has in the past neglected the bulk of the organisational layers focussing on the executive elite, being all male, and in more recent years, on doctors and nurses. This connects back to hospitals as hierarchical institutions, dominated by those that can afford education or come from privileged backgrounds, or those perceived as being of most value within a hospital organisation. These groups held positional power and as such directed much of the heritage collection processes focussing on either their professions, medical specialties, or departments. Interview Respondent 1, a female executive of 25 years employment service expressed a sense of being ignored and undervalued by the organisation as represented by the collected material heritage and associated organisational stories. In their view, non-clinical staff are both undervalued and overlooked which suggests their stories hold little significance and value to the organisational history. They suggested a change in collection practice would better reflect the Hospital's history and openly demonstrate the importance of other operational areas of the Hospital.

> **IR1:** *I think something that's often **unvalued** in the history of particularly health care organisations is the **little people** who make it tick. How did the cleaners used to live in 1892? What about the cooks and the kitchens? You know, the porters and their stories kind of thing. So yes, we absolutely need to tell the stories of the doctors and the nurses. I'd love to see more storytelling about the development of the allied health profession. Very biased there, being my background. … So maybe some storytelling about the growth of our corporate services and all of those support services that make a hospital tick is part of our history as well. That's **overshadowed** by the vision of doctors or nurses.*

The selective nature of heritage collecting, and the act of identifying and separating the valuable from the worthless were common themes in the interview and focus groups sessions. Respondents

noted the challenges regarding the recognition of heritage, and the nature of human behaviour surrounding the active assessment of heritage and contemporary organisational objects.

> **IR2:** *Kids these days actually don't know what to do with a dial telephone. And for our generation, it well yeah, derr, you pick it up and you dial ... and it's only then that you are* ***challenged in its absence*** *that I think you realise that it's a part of your heritage because if you don't hang onto it now it could be lost forever. And maybe that's the definition of heritage is, it's at risk of not being there at some point in time … I think sometimes it's a case of we don't realise what we are at* ***risk of losing*** *until we are on the precipice, and sometimes until it's too late … And I think sometimes it takes that fight at the last moment to go, hang on a second, let's not toss this in the bin, and we probably don't always get it right by any stretch of the imagination.*

Contention exists concerning the identification of everyday mundane hospital objects with some respondents noting heritage value occurs either by association or through retrospective processes that identify the object as contributing to the organisation is some way. Under this framing, mundane objects cannot be determined as containing possible heritage value as value determinations are reliant on the passing of time.

> **IR9:** *I think over time then the en masse objects do become more important. But I think at this specific point in time, you can't look at something and judge if it's going to become that or not. It's only with* ***retrospect*** *that you can do that. So, I guess like a simple pen would not have any value, but if it was a pen used by someone important or if it was used within a certain scenario and then that was then preserved, then it may become part of the heritage or the cultural heritage … I don't know if there is a defining criterion being like after 10 years this then becomes heritage, I think it really depends on the* ***value*** *of it and how its* ***contribution*** *to the place or to the people around it. So, I guess a simple pen would not have any value, but if it was a pen used by someone important or if it was used within a certain* ***scenario*** *and then that was then preserved, then then it may become part of the heritage or the cultural heritage.*

Further to this, Interview Respondent 11, a younger member of staff employed at RPA for less than six months saw no cultural heritage value in everyday work objects. They didn't identify modern buildings or health care technology as emergent heritage.

> **IR11:** *I just think that they've been around and that's sort of the way that it is, they are just work objects that we* ***use every day****. I don't think, would I think of the history regarding them, no. I don't attach any great value or anything.*

Alternately, Interview Respondent 5, held a more complex view, suggesting that time increased the value and meaning of cultural heritage. The nature of an objects use, or its past associations don't necessarily diminish the object's value. They held that an object used en masse within the organisation contains more value than ceremonial objects used on single or rare occasions.

> **IR5:** *But I think if there were 5000 of them in a hundred years' time, it's* ***more special*** *to me at least because that's what the staff would have been using. If there's only a small number or presumably they're special gifts for 25 years of service, it's not as special as the pen that's being used every day. So, I think in a hundred years' time it will have more value because it was common now.*

Alternately, Focus Group Two Respondent 4 suggested that objects require a deliberate attachment of value to be considered heritage. This implies a lack of understanding surrounding heritage and the implications of association and collection processes being driven or manipulated by selective groups or individuals.

> **FG2 R4:** *But I don't think it's part of the heritage until someone's actually* ***attached*** *any* ***value*** *to it, like that could become part of the heritage. Someone in 50 years could find it and go wow, they had paper book stands with a branded cover. It's not a part of our cultural heritage in two years' time necessarily. Until someone thinks it's important, it's not a part of it.*

Nurses developed the initial museum collection, and administrators the initial archival collection. Both collections demonstrate limited and focussed material collections based on what these departments deemed valuable. This perpetuates the exclusionary nature of organisational heritage collections and leads to organisation heritage loss. Interview Respondent 1 further supported this by suggesting that a lack of analysis and understanding surrounding mundane organisational objects leads to heritage loss, and again only through retrospective processes are staff determining or identifying value in organisational artifacts. Explanations surrounding this included the nature of the

workload and staff being significantly focussed on their role and not on assessing the changing nature of their role including changes in the surrounding organisational objects.

> **IR1:** *I think that is the really hard part, in that we often don't **appreciate** what our cultural heritage is until sometime down the track, so if we look at things that have been lost, things that we haven't valued at the time. I mean I worked in food services here for many years, so if you think about what we didn't **value** at the time … yes that's just one of our diet handbooks ... oh yeah that's just the equipment we use in the kitchen to cook with. Because we can't envisage a time when they won't be there, and what could replace them and, in some ways, when they are gone or no longer in use that we go 'oh'.*

Focus Group 2 Respondent 4 noted a need to actively identify contemporary aspects of the organisation that hold meaning and value to ensure they are collected and preserved. They further suggested this knowledge may then assist with current and future management strategies of hospital cultural heritage.

> **FG2 R4:** *The trick [is] probably noting what's happening now and see what aspects of this are going to be [kept] through natural means, not through being **pushed**. What are people gonna **care about** in 20 years [and] to try and make sure that's taken note of. If you can figure out what people will care about in 30 years, you can try and make them care about it now.*

This statement strongly connects to notions surrounding emergent heritage. During the COVID-19 response, imagery was captured to ensure an accurate historic legacy was captured. RPA staff were aware of the historical significance of events unfolding and much of this has been captured and showcase in the picture book: Humans of NSW Health and other RPA publications discussed in depth in Chapter 2. In this sense, emergent heritage was used as an organisational strategic tool conveying status, value, tradition, legacy, pioneering behaviour, and leadership. Management strategies can then also assist with decision making surrounding how cultural heritage is determined and valued, which by extension can assist in governing organisational collection behaviours. Organisational members need to have a clear understanding as to the organisational collection and preservation process and rationale in order for them to acknowledge the nature and value of heritage.

> **IR5:** *[Y]es, definitely there needs to be that understanding that today is **tomorrow's heritage** and history and particularly with a facility like this that presumably will be around in a hundred years' time … The things of today are just as **important** to document, if not keep, at least document properly and understand that they're the **future** cultural heritage …*

By building a framework of understanding surrounding hospital heritage organisational members will be able to acknowledge and appreciate the heritage value of the mundane but rare organisational objects as opposed to what might be considered a significant and valuable object based on artistry or financial value. Further, that identifying the various representations of heritage may come with conflict as preservation may interfere with or interrupt progress or change, and by extension effect the organisational core purpose of delivering effective healthcare.

> **IR1:** *I think we are **valuing** keeping a style whether it's building, or equipment or facade that we just simply don't do any more. So that's where I think it can be quite challenging, when you look at houses being listed for heritage and stuff like that. Are we doing it for the sake of doing it, versus, if we don't do it for a certain number or a certain percentage, we'll have **lost** this piece, so it means we can never move on, but it's finding that **compromise** between enough examples of that piece of architecture, of that piece of equipment, of that physical thing, that we've got that **retained memory**.*

Several respondents noted that much active collection and deliberate heritage preservation occurred regardless of management or staff perspectives and attitudes surrounding heritage. Interview Respondent 13 demonstrated an extremely strong response surrounding the management or mismanagement of what they identified as heritage. The word 'stolen' was used to describe their act of heritage preservation suggesting they found it necessary to steal the object to safety. Such behaviours are strong representations of personal values and beliefs.

> **IR13:** *I'm quite interested in **old things**, so I don't like to see things being thrown out or **changed**. So, when I talked to you about their redoing Gloucester House level 2, engineering are cleaning out rooms and there's a glass sign for Sydney Cancer Centre…. I've **stolen** it. Well I haven't stolen it, but I've put it in the office cause I think putting it in the bin is horrendous.*

Self-identifying as someone who values 'old things', Interview Respondent 13's values significantly influenced their organisational perspectives, decision making and behaviours. They openly disagreed with standard practices and circumvented normal procedures to preserve material objects they deemed valuable, but which the capital works team deemed worthless. By identifying the Sydney Cancer Centre glass sign as significant they reframed it as emergent heritage. This reframing transformed that object from mundane organisational artifact to an object with heritage status. Further, The Sydney Cancer Centre relocated from main building to Gloucester House during the 1999-2005 redevelopment and then to Chris O'Brien Lifehouse in 2014 meaning the signage retrieved by the staff member was approximately 15 years old. This highlights a possible divergence in value placement between some members of the capital works team and some members of administration based on age of the object. Capital works staff members may have viewed the signage as modern operational wayfinding with no value, while Interview Respondent 13 identified it as material heritage. The issue however with this statement, and the interpretation of the respondent is that the capital works team may not have been responsible for disposal of the signage. Site demolition is generally performed by contracted employees with no understanding of the Hospital's history or of the value in identifying and collecting material heritage during redevelopments.

Another staff member saved heritage from disposal during a major redevelopment phase of the Hospital. Key to focus group session dialogue and exchange was the 'wow' exclaimed by the group. A shared sense of excitement, wonder and disgust emerged regarding the possible theft and inappropriate use of something otherwise significant to the Hospital's history. Further, that Professor Blackburn perceived value in the granite plaque during the 1977-1983 redevelopment when other members of staff did not. While impossible to know what his motivations were, adapting the plaque into an ornamental coffee table suggests both sentimental and value.

> **FG1 R2**: *Yes, I know the story. Ian Pegler [museum volunteer] told me you and he visited Blackburn's house [long-serving doctor] and he had one-half of one of these **plaques** [indicating image of granite donation plaque in original 1882 position] on his balcony used as a coffee table.*
> **FG1 ALL**: *Oh wow.*
> **FG1 R2**: *and while that may instil an initial sense of **horror** in us, that actually demonstrated a **connection** and that he **cared**. Cared enough to save it from the bin.*

On the other hand, some staff demonstrated a need to keep everything, regardless of significance, as a representation of organisational heritage.

> **IR5:** *But yeah, M who I work with who's kind of the admin person and so on, she hates me throwing anything out. 'That's our history.'*

These traits can prove problematic as staff hoard organisational objects or documents causing departmental or organisational disruptions. Similarly, Interview Respondent 13 also noted collector and hoarding behaviours in the district Relocations Manager. The Relocations Manager has been employed at the Hospital for over 20 years. He both collects and stores mundane organisational artifacts but has in the past recognised and preserved objects deemed worthless at the time. Such perceptions of value are a response to both issues with storage and the resources required to preserve the objects.

> **IR13:** *Just look at RP, he **stores** stuff away forever, like those arches [indicating arches in photo]. If it wasn't for him those 100-years-old arches would be firewood.*

Use of the word firewood highlights the respondent's belief that the arches were deemed worthless and a product to be discarded and not saved as a significant object of organisational history.

Further, on occasions the Hospital receives heritage donations and is notified of possible heritage donations. The collection rationale and behaviours surrounding this have in the past varied, based on the view of hospital executive staff or chief executive, and again available storage space and resources. Heritage management under these circumstances has been a source of tension between the need for further clinical care and modern infrastructure. On one hand, actively pursuing and collecting hospital heritage further supports connections to the organisations past, but on the other interrupts the progression of modern healthcare facilities. Central to the statement by Focus Group 1 Respondent 2 is that hospital staff have not made an assertive effort to reclaim lost heritage which is suggestive that it has at times been a low priority and of limited perceived value to the organisation and staff members.

> **FG1 R2:** *The thing I alluded to before, which is that heritage is scattered in various locations, and over the years the **messages** have been different about whether the Hospital wants heritage items or not. Because often people suddenly have an estate to deal with, with items*

*that might be of interest to the Hospital and the Hospital really isn't in a position to receive… So, we've got an issue of being **selective** of what we try and get and acquire back, and we haven't really made a **strong effort** over the years to acquire heritage pieces back.*

In conclusion, this section has explored interview and focus group data relating to **heritage identification, collection, and preservation**. As demonstrated above, the stories, conversations, and commentary with the 32 participants yielded rich, complex findings. Cultural heritage for them was complex, fluid and changing. They saw cultural heritage as the cultural built heritage, organisational and corporate memories, organisational stories, organisational artifacts used in the daily operation of the Hospital, staff members and organisational behaviours, including innovation and traditions. Respondents noted that the value and meaning of organisational cultural heritage is at times reliant on retrospective processes. This was challenged by some as they conceived heritage as a multilayered process and complex phenomenon noting emergent heritage as a key component associated with organisational development. Respondents also noted the current heritage collections are a skewed view of the organisational history in that they reflect a bias towards those staff members in positions of power and are disproportionate representations of the organisation. The heritage of RPA is interpreted as a white, educated elite male story, and a story focussed on a core collection of staff including doctors and nurses. This has occurred to the exclusion of staff members in other roles deemed to be of less importance and has as a result been clearly identified as a significant driver and focus of heritage identification, collection, and preservation. This exclusion has left some respondents feeling less valued by the organisation, perceiving the current collection of material heritage as perpetuating male patriarchy and not accurately reflecting the nature, character, and development of RPA over the last 50 years.

Engagement Challenges

The second sub-category to be merged under Member Value was that of Engagement Challenges. Engagement Challenges encompasses methods and modes of staff engagement with organisational cultural heritage and the varied associated issues surrounding engagement as identified by study respondents. In this context engagement requires that an interaction take place between the organisational member and organisational cultural heritage. Many single or similar child nodes emerged including lack of connection, new staff, age related, outsider feelings, primary purpose of employment, time poor, unmotivated, transient staff and visibility as examples. Numerous engagement challenges emerged surrounding cultural heritage at RPA. These challenges impede on member interpretation and comprehension of heritage meaning and value. Some challenges were

externally imposed as a result of environmental circumstances, and some were occurred as a result of member beliefs, values and memories. Challenges ranged from staff displaying a general disinterest in heritage aside from that derived from their own department to staff citing a lack of knowledge regarding heritage and the organisational story, and consequently being unable to build a connection. Other respondents noted that they are at work to work, and not to visit museums and experience cultural heritage displays, while others cited a lack of available time.

Interview Respondent 9 noted a general lack of connection with organisational heritage and felt their response was an attribute of their age group. Further exploration suggests this is also in part due to the nature of the modern hospital work force having become more flexible and transient. Doctors are employed across multiple hospitals and health districts, often moving around multiple NSW health facilities within the space of 12 months. This either fractures deeper connections to the organisation or prevents the development of deeper connections. Further to this, the more time spent at one hospital, the more that staff member becomes exposed to the organisational history and heritage thus developing deeper connections to the organisational culture and identity. Other workforce areas including management, nursing and capital infrastructure and engineering are becoming increasingly transient workforces. Staff have an increased ability to move between health districts and services, or even into private sector specialised health related industries with ease thereby challenging the nature of organisational heritage engagement.

> **IR9:** *[L]ike I said, I see these things around and I'm like, okay, that's cool. But like I just don't have that* ***personal connection*** *with it. Whereas if it's more of a departmental area, then that's different … And I think it's definitely like an* ***age thing*** *as well. My age group, I feel like we* ***connect less*** *with the past. We'll put* ***less value*** *on it compared to other people. And I know even just talking to other people within my department, they put a lot more value on the past and what's helped them to become where they are and like the organisation. Whereas I think people my age group don't as much.*
>
> **Moderator 9:** *So, the common thing with your age group and then moving into my age group is that, you know, average employment in roles is four years.*
>
> **IR9:** *Right. A role or a job, because self-satisfaction and you know, workplace enjoyment for us lessens and disintegrates. We look to next, what's next.*
>
> **Moderator 9:** *Do you think that's part of that inability to connect? That there's no one hanging around long enough?*

IR9: *Yeah. And I also think it's gonna make me sound really horrible. It's really* ***self-involved****. People look in more than they look out. They want that internal satisfaction instead of the external.*

Interview Respondent 8, employed for 16 years, further supported this notion. They cited a generational shift with people remaining in roles and jobs for shorter periods and therefore fail to develop strong organisational connections and associations. This inability to forge connections to the organisation or specific departments leads to engagement failure. They felt individual departmental histories could assist in connecting new and short-term employees with the organisation and that these were largely absent across the organisation.

IR8: *It's funny because I think that we've got two groups in our department. We've got the older ones who have been here for much longer. They are very attached to that history and the younger ones really aren't at all. Whether it's a* ***generational*** *thing and whether they'll move away from those* ***connections*** *as people move from job to job more freely, maybe people will lose the connection. Whereas the people who have been here for a long time have, you know, really seen the* ***department change*** *and so on. So, I think that it would be extremely significant to have something [referring to heritage items and wall histories] in the department. And they've often said, you know, that we should have those. Particularly some of the really early people who obviously I never met. For the younger ones, I'm not sure how they would react to it actually … But then I wonder if that's a* ***generational*** *thing. As so with, you know, the baby boomers and so on, that's what they've worked towards, being part of an organisation and so on. Whereas the younger generations aren't really wedded to that at all.*

Focus Group 1 Respondent 1 further noted the generational divide between long serving and new staff members. New members found the interest and fascination with departmental history and heritage by older staff members as unusual. Staff with long employment histories at the Hospital, and in particular departments demonstrated great pride and a sense of joy in commemorating their history and heritage. By actively using heritage during celebrations and staff gatherings they were strengthening their organisational and departmental connections and bonds.

FG1 R1: [*W]e did a thing in the physio department and invited a lot of the staff that had been here before, and we had up a lot of the* ***old pictures*** *and things. You know to me that sort of*

*seemed normal but the junior staff sort of looked at it and thought it was **strange** how we were all **interacting** with it and each other. We were sort of like them before and they didn't see us like that now. But it changes doesn't it, but it's important to realise why we are here and these **great foundations** of this hospital, and **what it means** and what it can do.*

Some respondents felt a sense of embarrassment over their lack of knowledge surrounding the heritage and history of RPA and their resulting failure to recognise the value of organisational cultural heritage. They felt that if they were better informed as to why they should value it, they might then better comprehend its value and therefore experience an increased connection to the organisation and feel like less of an outsider. Interview Respondent 11 cited a lack of opportunity to learn the history of RPA and therefore failed to identify value.

IR11: *That would make me **value** it more to know what value there is in the heritage. Yeah. Knowing a bit more about the history of it, the history and the stories. So, yeah, all the stories… I know that it's important to other people, but not necessarily to me, but that's because I don't really know too much about it. So, if I could have those opportunities to learn, I can engage a little bit more in things like social media or ways to get maybe like the newer people or younger staff that look at that sort of stuff… Whereas **coming in new**, I don't know very much … cause I think RPA is something that's special. And like I said, people get excited when I tell them that I work here and I **feel almost stupid** that I don't really know.*

These sentiments were further explored by respondents when discussing employment orientation. There was an absence of historical information provided during the orientation of new staff members which again left new staff members feeling isolated and excluded with regard to deeper organisational connections and sense of belonging.

IR10: *[C]ause I was thinking when I was coming here having my **orientation** like back in June, I don't recall much. I'm sure they would've said, 'Oh RPA Hospital was built in this year', but not much. Nothing that stuck anyway.*

This failure to actively engage staff was also articulated by Focus Group 2 Respondent 1 who noted it as a missed opportunity to build staff repour and strengthen workplace pride and sense of ownership and belonging. Were new staff members oriented to the Hospital's history it was thought

they might identify more strongly with the organisation or with their department and immediate work colleagues.

> **FG2 R1:** *But when I first came on board, whenever I asked or commented on things, nobody was actually able to give me any **information** other than 'Yes this was the woman's hospital, lots of babies were born'. People are able to say, 'I was born here', but nobody told me about how it came about, you know, where the funding came from. You know, the **context** where we all know, you just need to imagine what the city looked like 137 years ago. And to put it into that context is awe-inspiring. And I think it's a shame that people don't know enough about their history cause then they would feel that they **identify** with maybe the whole service more and with the location. And I think it's a missed opportunity.*

While this lack of knowledge caused some respondents to remain disengaged with RPA's history and physical heritage, Interview Respondent 12 noted the depth and breadth of the organisational back story, and a wealth of knowledge and organisational capital waiting to be effectively used.

> **IR12:** *I **never knew anything** about any of that. I don't even know who Scot Skirving is and there's the Scot Skirving lecture theatre. So yeah, there's so much of all this history that you don't even realise is history until you get to know about it, and you hear about all the stories.*

RPA and the University of Sydney have a long-standing institutional link that commenced with the foundation of the Hospital. The Hospital serves as a training ground for doctors, nurses, and many allied health professionals. These links create a pre-connection for some respondents but cause issues for others who expressed a sense of exclusion having been educated elsewhere. The strong focus on the university/hospital connection was perceived as an instrument that favoured University of Sydney graduates which further underpins those elitist perceptions that surround sandstone universities.

> **IR11:** *[B]ecause I didn't go to Sydney Uni, I feel like I would've known more about RPA as well. I feel like I'm a little bit of an **outsider** sometimes. But obviously I've toured around the campus and stuff. I know the Kerry Packer building because I started in renal transplant when I first started here. I know that he had his transplant. I sort of understand a little bit of that background.*

Moderator 11: *Tell me more about what you just said, about feeling like an outsider and not having come from Sydney Uni.*

IR11: *Well, I feel like if I was at Sydney Uni that RPA would have been our local hospital to do placement, I didn't have placement here or anything or I didn't have my hospital orientation here. Like a lot of students from Sydney, they get all the Sydney Uni students here. Whereas Wollongong has separate hospitals. So, I think that I would have just had a bit more of a background, whereas I've sort of started here fresh, you know, completely new environment. But I don't really know much of the* ***history*** *behind it all to be honest.*

A more detailed coverage of the history and heritage during new staff orientations would greatly mitigate feelings of exclusion and isolation for new staff members and would again support increased staff member well-being and sense of belonging.

Making heritage accessible and visible was cited as one of the most common engagement challenges faced by respondents. In making material accessible and visible cultural heritage functions as an engagement tool reminding and reiterating the history of the Hospital. Further, they regarded heritage across the organisation as a pleasure to view and engage with.

IR8: *But making that stuff* ***available*** *and* ***visible*** *and* ***reminding*** *people of that, and I guess it's the visibility that reminds you. So, you know, I think the* ***nicest thing*** *is walking through the, the main foyer, as you walk into the main hospital and you see all the old photos. And the stain glass windows and you know, there's some really lovely photos in there of nursing and the old wards that were set up and so on. So, I think for me, it's about being, for it to be* ***recognised*** *and* ***acknowledged****.*

Other key engagement challenges identified were those associated with time and employment priorities. Interview Respondent 1 felt the museum location provided a barrier to visitation and therefore engagement.

IR1: *I think there is value in making it more* ***visible****. So, if it is things like making sure a lot of our heritage pictures are in areas that staff walk past every day or our patients and our visitors and having displays. And it may mean from a space point of view that they have to turn over. So, you know, as we walk into it, maybe that could be one of the things that with the front foyer, and I know as we go in further, there's some displays, but actually creating a*

*built environment where it's possible to continue to display those items of heritage so that people are **reminded** of those **links** to the past. Including then some of the stories of the people who use them and how they use them and why they use them and what they were used for and all the rest of it. So, a lot of the **storytelling** that actually goes with that as well. I think people are fascinated by that stuff. The museum becomes the curating space but making some of the stuff that is our heritage really accessible. Because at the moment, it means going out of the way, which a lot of people are simply not going to do, 'Oh, I really have to get to that one day' kind of thing. But to make it really accessible so when you're walking in the front door, when you're walking in one of our other buildings, seeing that heritage and seeing it really visible. It's just not accessible enough.*

While other respondents saw value in the development and dispersion of heritage across the campus many had not made time to visit or view it. Some respondents had never visited the RPA Museum as they perceived their time as being allocated for employment responsibilities and not pleasure, and were in their view, time poor. They did not view the museum as an educational and engagement tool, and failed to see how engaging with heritage would strengthen their connection to the organisation or stimulate any additional insight into their role at the Hospital.

Moderator 11: *You've seen the **timeline** [Renal Department History Wall] on the wall on PMBC L2 [Professor Marie Bashir Building].*
IR11: *No, I've not been to the new one. I've heard about it. Like I've not, I've seen a photo of it cause there's a dietician on there, I've seen that there's a huge thing and I think that that's beautiful. Like I've not physically been to it. **Haven't had a chance**. But I think stuff like that is really nice to do.*

Moderator 8: *You haven't been to the museum before?*
IR8: *No, I haven't been to the museum.*
Moderator 8*: Can I ask why?*
IR 8*: I've just **never made time**. I guess I think I'm here, I'm getting paid to work not to go look in a museum. So, I would probably feel a bit **guilty** about going to the museum during my work time.*

In conclusion, interview and focus group respondents identified several challenges in engaging with RPA cultural heritage. Key to these challenges were time, access, and visibility. While value was

acknowledged in RPA's heritage, walking around the campus grounds, visiting the museum, and reading heritage displays and exhibitions required time that some respondents felt they didn't have or that was purposed for employment activities. Further, that some respondents noted a feeling of guilt when allocating time towards non-core employment activities and refused to do so. Due to ongoing staff shortages, workplace pressure and stress would be further exacerbated by actively seeking out and engaging with heritage during work hours. This feeling of guilt extends to other staff who identified that their failure to understand the value of cultural heritage directly affects their perception of it. They viewed it as 'nice' and 'important' but could not recognise the deeper implications of the presence of heritage and so made no effort to understand or acknowledge it further. This was more prevalent in younger staff. Both younger and older respondents noted generational differences in engaging with RPA's heritage. It was felt that younger staff demonstrate less interest in the past which on one hand is linked to modern employment behaviours, and the transient nature of hospital employment, and on the other, a generation of staff that one respondent interpreted as being inward looking and self-centred. Respondents did however suggest that heritage could be more actively and effectively used to educate, inform and by extension promote inclusiveness and belonging amongst new employees.

Engagement Benefits

The third sub-category that emerged from the data relating to Member Value was the theme of Engagement Benefits. Engagement Benefits are positive organisational member outcomes associated with or derived from contact with RPA cultural heritage. Examples of themes that emerged include conversation starter, behaviour influence, powerful response, pride, gravitas, sense of belonging, reverence, awe, connection to real people, build team connections, and engagement motivator. These themes suggest that the presence and use of heritage offers significant benefits to organisational members that indirectly and directly support a conducive and positive workplace experience and environment.

The RPA Museum publishes a fortnightly digital history page on the SLHD intranet blackboard. Known as the 'Did you know ...?' campaign, it focuses on one historic image as centre piece to detail a small portion of RPA or district history (see Appendix E). When referring to the RPA Museum, campaign some respondents noted that this digital heritage program stimulated discussion and created dialogue and connection amongst team members. In providing a central point of focus and springboard for conversation, digital histories stimulated active engagement in organisational stories. Focus Group 1 Respondent 1 noted such engagement can influence and shape organisational

member behaviour in how members connect and engage with one another. Team members actively sought the heritage documents out, printed them and passed them between colleagues which generated much discussion around the changing nature of RPA and wider society. They also promoted excitement when exploring what each staff member had seen and experienced in the past and increased that sense of shared experience and knowledge which in turn strengthens the bonds between departmental colleagues. The coming together over these documents created a fortnightly focus and medium for staff to increase their organisational sense of belonging.

> **IR2:** *[T]hey are good **conversation starters**. And often in that conversation someone may know another story and another story, and it sort of can grow like that. I was telling someone last week about the ambulance driver [referring to a particular digital campaign] and the fact that he had to go and drive down the coast, which is Prince Henry Hospital. We're going, 'I'm wondering how many times a day you can do that'. So, it starts, you start **reliving** it, you **visualise** how long would it take the horse and cart to go there to bring people back from the city with typhoid? What would happen to the nurse and the driver, would they get sick? And so, it just starts to **come alive** and you think how **different** it was then. Then you have an **appreciation** for how much, how far we've come forward.*

> **FG1 R1:** *[O]ne of the guys in the department is interested in history, so I always print out those things you do [RPA Museum: 'Did you know …?' campaign] on the intranet and give to him. He's actually started **passing them around** the department, so they are all very interested in them. It sparks some **chatter** about the history of the place. Yeah, I think it can **influence behaviour** when you reflect back on some of these things and can influence the **connections** in how people work together.*

Non-digital graphic wall historic timelines are located in three locations across the campus. The Woman's and Babies Unit, the Renal Dialysis Unit (see Appendix F) and KGV building nursing all have historic timelines detailing the journey and history of their departments and units. These were seen by Interview Respondent 7 as performative providing a signal to new staff members that their new place of employment comes with history of which is considered significant enough to be showcased and celebrated by the department. This suggests that the department cares about and values its history, in that it feels it necessary to educate and inform staff and visitors of that pride. These heritage walls also support a sense of belonging amongst current staff members who can identify as a part of the heritage lineage of their department. This in turn may attract new members viewing it

as a positive working environment. Further, that new staff are joining and becoming a part of something significant signalling departmental expectations.

> **IR7:** *And I think that then would give anybody a sense who's starting here that they are joining somewhere that has a **long** and **proud history** and that should, it doesn't matter what position they're coming in to do, it would give anybody a sense of achievement and **pride** I would think, that they're joining an organisation that does have a **prestigious** and **long history**. That's how I would feel anyway. And it is quite possible that a lot of people would start here, regardless of what field they're coming in for, really have no idea, and I personally think it would **boost general morale** for some of those people to see that.*

> **IR12:** *I think what happened when people found out about the wall then that everyone wanted to go down there and have a look at it and then everyone kept **hearing** about it. So, I think if you have that **communication** through a team about something and then other people hear, they're like, 'Oh, you might want to work on the renal team. It sounds like, you know, they have a **good environment**' and yeah, say and think things like that.*

Communicating and celebrating milestones through wall timelines can also assist in building deeper connections to a team or department. When describing the Renal Unit team that delivered the 3000th transplant, Interview Respondent 11 demonstrated excitement and admiration wishing they had been a part of that occasion, and then becoming a part of the history of RPA.

> **IR11:** *Yeah, I think knowing where you are working and the history behind that is important and makes you more of a part of it. Like, if I don't know, then how can I understand? Yeah. That's what my thinking is. When I was in renal transplant, they had their 3000th kidney transplant [operation]. If I was a part of that [surgical] **team**, then I would feel, 'Oh, I'm part of like the **history** of that'. So, I think that that's interesting that they **celebrated** that, and I think it was really nice.*

Interview Respondent 12 was excited to consider they are a part of that historic moment, commemorated on the wall of the unit. They also noted the inclusive nature of the timeline which showcases faces from each specialty, theirs being Allied Health. By having their face on the wall alongside various doctors, surgeons, and nurses they felt a part of the team and equally celebrated and valued as an integral member of the unit.

> **IR12:** *Oh, that's **fantastic**. When we, cause we had walked in when it was being redone. I don't know, I haven't been over there for a while. But everyone in the department was **talking** about the wall in the renal team. They're like have you seen the wall? Have you seen the wall? It's so good … And I think the photo of the team up on the wall, which has me in it, is an MDT team. So, it had like nurses, doctors, dieticians, a pharmacist. So, it wasn't only just nurses, there wasn't only just doctors. Yeah, and it wasn't only just seeing doctors, it was junior doctors. So, I think it shows that there's more within a team, **everyone's included**, everyone is **valued**. No, I think doing this has made me realise that I have actually got a **strong attachment** to the Hospital because of its cultural heritage. I didn't actually have **time** to **reflect** and think about before, but it's really for me, like working with a team who have done 50 years of renal transplant is just so **valuable** for me. Yeah, yeah. Yeah. … It just makes you think, 'Wow, I'm actually part of this same …', and I'm like, 'Wow, my photo's on the wall.' Like it's just a nice, it's a **nice feeling**. You feel like you **work so hard** that you've got, you know, at the end of it, you're like, I'm part of that team, or I'm part of the Hospital who's been around this long.*

Feelings of ownership and pride extend beyond departmental heritage displays and are experienced when engaging with wider organisational heritage spaces. Respondents noted that through the preservation and presentation of built heritage spaces and movable historic artifacts, strong emotional connections were developed and maintained. A sense of ownership, pride and of belonging were described, particularly when discussing the 1882-built front entrance and foyer of the Administration Block which contains a collection of busts and portraits of founding staff members. Respondents noted feelings of connection toward the organisational members who came before them and felt as though they personally were now a part of that story and journey of RPA. Interview Respondent 10 cited the emotional power of feeling a part of that historic journey having formed a connection that would remain with them beyond the term of their employment with the organisation.

> **IR8:** *I think you feel really **proud** of being part of a very **long-standing history** of people who have walked through here, and you know, I know for our department, it was the first dietetics department in Australia that was set up here. So, to be part of that as well. So, knowing that you're **walking** where people have, I guess not **trail-blazed**, but you know, similar. So, it makes you feel **proud** is what I think.*

IR10: *When I was a student looking at RPA – this big beautiful hospital with lots of history and lots of significance and in the medical world and* ***being a part of it*** *– I guess that's the* ***pride*** *again. But in terms of the cultural significance, what it means to me just knowing that I get to work in hospital that has kind of paved the way in a few areas, many areas for medicine and health care. And so being a part of that is really, I know that I'll hold onto that even if I don't stay at RPA. Yeah. I think that's what it does for me. I get to be part of the cultural history in a way. I guess what I get out of it, it's just knowing that there is a lot of history that stands there and you're walking through this like* ***beautiful*** *building that's had so much* ***cultural significance*** *and* ***change*** *and just knowing that and it's kind of, it is kind of like a museum and you're just in it. You're a* ***part of it****. That's* ***powerful****.*

IR12: *I felt really* ***proud****. I just felt, you know, there is just so much significance to this hospital. There is so much history. It just made me feel so proud and it made me feel like this hospital's been around for such a long time and so many people have* ***walked*** *through these doors. And I often thought about what this area was [indicating original front foyer] before it was the foyer, you know, what was here. And it just makes you feel really, Hmm. I dunno. It just makes you feel proud to work in something that's been around for such a* ***long time****.*

Emotional power suggests an increased emotional strength which can underpin and support staff member drive, resilience, and adaptability. When staff members feel empowered by the journey and history of the organisation, they may undergo an increased sense of inspiration and motivation, regardless of hurdles or challenges faced. Further, the removal or loss of cultural heritage removes the known and recognised legacy surrounding the organisation and various departments, which in turn affects member sense of responsibility and obligation towards the organisation. In their view, the presence of heritage served as a reminder that the Hospital is guided by 'pioneers' in healthcare which then reinforces organisational memory. Feelings of organisational identification were strong in Interview Respondent 10 citing their role and responsibility to protect the heritage as a 'duty'. Notions of duty suggest they hold very deep feelings and connections to the Hospital and to their position. They furthermore identified their strong connection through a naming right and a membership of a unique group of individuals. This suggests the presence of cultural bond amongst staff members.

IR2: *It would impact on it because there's nothing to remind you of people who've left a* ***legacy*** *and with a legacy comes your sense of, or a sense of* ***responsibility*** *and* ***obligation****. So, these are the people that were* ***pioneers*** *in their area. You walk in and you're reminded, you see Schlink, you see Blackburn and whatever. And you think this is a place of* ***greatness****. If they're not there, there's nothing to remind you that this is the, this was the* ***expectation****, or this is what you're working at. This is where you are. Yeah. You've arrived in a way.*

IR6: *I hope it doesn't sound odd, but I actually view it as part of my* ***duty*** *to actually do that too, to* ***keep*** *that heritage. And you know, there's a term you may have heard, which is, you know, you're an RPA man or an RPA woman and, you know I think it's very real. People have that* ***affinity*** *with the Hospital.*

Interview Respondent 5 similarly built a connection to the Hospital through engaging with the front foyer space by identifying tradition. Such connections build capital that in their view provides a strong central narrative that is immutable and not easily eroded by mismanagement.

IR5: *That* ***connection*** *to that tradition. And again, I, when I first started as an employee, not the chaplain's assistant, already I felt a connection with the Hospital because of the* ***cultural heritage*** *around me.*
Moderator 5: *Your* ***long personal association****?*
IR5: *Yes. And that's maintained today. Even when there might be something that happens with the executive or whatever and I roll my eyes, they're not* ***eroding*** *the* ***capital*** *really. I see them as more* ***transien****t than the Hospital, as we all are. Every single person here is more* ***transient*** *than the Hospital.*

Such connections were in part responsible for keeping Interview Respondent 4 employed at RPA. They cited a need to feel connected to the organisation as a key aspect of continued employment and loyalty, and the presence of material heritage, in combination with other factors supported their sense of belonging, and in part boosted their motivation, particularly when experiencing challenging periods within their role.

IR4: *Yeah, I think because the work like as a midwife and nurse is quite emotionally and physically draining, I do appreciate the sort of* ***environment*** *and* ***feelings*** *around the Hospital that make me feel* ***connected****. The* ***old statues*** *and* ***buildings*** *included. Cause if they weren't*

*there, I'd probably leave or go find somewhere else that makes me feel more connected, but that's in **combination** with other things as well, the **people** that you work with, the **management** of the Hospital. So, it's kind of all things together. That's what makes you want to stay or makes you feel **drawn to stay** if times are tough and you thought that other places were better.*

For Pilot Focus Group Respondent 1, the colonial built heritage provided a strong connection to their birth nation and home environment in Scotland. Several founding members of staff were doctors by profession, and we trained at Edinburgh University, a noted medical training institute during the Victorian era. How this impacted on the early development of the Hospital is yet to be determined, however the values instilled by the university and its training methods will have impacted decisions surrounding the development of heritage at RPA. Key to this respondent's statement are those aspects of heritage that generate feelings of inclusion and connection, and exclusion and disconnection. If the built environment, statues, and moveable artifacts located across the campus provide connections to home and generate feelings of safety for one individual, they must also generate the opposite for another.

PFG R1: *so, for me it's a **connection** to **home**, I know that sounds like a daft thing to say but when I walk into RPA, RPA's architecturally similar to the Hospitals that I trained in at home, and because Australia is such a new country in comparison to Scotland…*

When shown images of the front entrance and foyer (see Appendix C) and questioned as to whether it should remain in its current form, filled with busts, old pews and artworks, respondents demonstrated strong opinions surrounding heritage. Interview Respondent 6 suggested that pride in tradition affects and shapes member behaviour. It provides meaning which also underpins that behaviour which they viewed as critical to member behaviour and deeper emotional responses. Key to their response was use of the work psyche which reflects those conscious and unconscious responses to organisational space and by extension, experience. How members experience the space and formulate meaning will impact on their wider response to their individual role and to the Hospital.

IR6: *Absolutely. I think absolutely keep it the way it is. Tradition, **pride** in that **tradition** I think significantly affects **human behaviour** and **human psyche**. So, without that, things don't have **meaning** and you could have, you know, with $750 million, knock that down and*

*have a brand-new spanking hospital with, you know, colourbond roof, etc. That's not RPA, that's not the history. And you know, I still feel very **proud** when we have a meeting in the old RPA boardroom. And just seeing the wood panels all the way, it just gives you a sense of **belonging** and being part of something really special. So, I think it's absolutely critical.*

Preservation of cultural heritage suggests to members that the organisation reflects on and cares about its own history and traditions. By showcasing material heritage, the Hospital is proud of its organisational journey. This behaviour in turn inspires complex emotions like awe and reverence which include a sense of wonder. Wonder is a key tool to those that work in fields of investigation such as healthcare, as wonder encourages learning and inquiry. Wonder can also enable better engagement to work colleagues, the organisation and life in general. Reverence additionally inspires confidence and a deep respect that again helps build and strengthen member–organisational connections.

IR7: *Think it's a feeling of **reverence**, of **awe**, of **authority of standing**. For me it's **proof** that it's been properly looked after and properly respected, which I find personally important. Not everybody would, but I look at it and understand that over the years it has been **recognised**, that this is something worth looking after and it is being looked after.*
Moderator 7: *And then with that, that sense of age, you walk through, you're surrounded by the people, the history, the aura, you said that sense of gravitas. What does it make you feel about the organisation?*
IR7: *Oh, it definitely inspires **confidence**. A sense of **belonging** as well. I think it does. And just in comparison to other modern buildings, it just has a **feel** about it that the more modern ones just don't have …*

Several other areas across the Hospital campus have individual historical displays specifically related to their specialty or role within the Hospital. The Radiology Department displays early heritage images across its department and two cabinets showcasing vintage medical equipment in the departmental waiting room. It was felt that such displays assist new members in understanding the history of the Hospital and medical practices through highlighting the practice changes and medical developments. Focus Group 1 Respondent 5 commented that patients and staff are regularly seen photographing the displays suggesting an interest in the progression and development of the department and technology used by the clinicians. Showcasing the various iterations of technology

and educational material provides a reminder to younger staff members regarding challenges faced by earlier medical practitioners.

> **Moderator FG1:** *What is that desire, why are they attracted to taking those photos?*
> **FG1 R5:** *They are seeing how their colleagues in the **past** have dealt with issues and how they are dealing with them now. We are often told we do things this way because we've always done it this way and so we've got that **connection** to the past and it's interesting to see with less technology how did people deal with the same issues.*

This knowledge also informs and educates younger staff in understanding the immensity of change that has occurred within the field of healthcare and why some processes and procedures might not have progressed when some have. Assumptions, norms and habits of new staff are quickly ingrained across the Hospital, and through access to heritage, staff are able to better understand the journey of healthcare at RPA and by extension find a better grounding within their field of employment.

> **IR1:** *I had to laugh, one of my younger clinicians was talking to some of our students the other day and he was talking about CIAP [Clinical Information Access Portal]…Turned around and said to me, 'What was it like when you were a student?' And I had to say, 'Well we didn't even have the internet when I was a student'. This poor clinician didn't know where to look kind of thing. So, I think that's where sometimes those **connections** remind even our younger people, the **assumptions** and **norms** that actually need to be to be challenged sometimes because the world has moved an awful long place over time.*

Engaging with material heritage displays and the stories associated with those artifacts also exposes and highlights the nature and diversity of roles held by staff across the Hospital, and how they have changed or stayed the same over the years. Interview Respondent 3 discussed that while nursing as a profession has changed, the feelings associated with the role have largely remained the same. They expressed joy in this as it excited and motivated them, which provided a source of inspiration and a connection to those staff members of the past.

> **IR3:** *I think with the nursing stuff, particularly nursing has **changed** so much since then and highlighting that at the same time makes you aware of what hasn't changed about nursing. And I think the nurses would probably feel that more strongly 'Wow, you know, that was so different'. But the same principles or the **same** sense of vocation are there, and you notice it*

*more because of all the other stuff that's so different and how they lived and how they were managed and the tasks they did like the **crappy**, crappy tasks, they did that you know, that nobody has to do anymore. You know, all that stuff is so different, yet they have the same **feelings** about the job and why they were there as we do now. I think that's really valuable. But yeah, the displays of the physical objects that they have in the foyer. I just love those. Here is a whole bunch of syringes made out of silver and attached to nasty rubber tubing … **educational value** of that. Both seeing what's changed and appreciating what's changed and kind of realising the implications of those changes.*

Celebrating key milestones and anniversaries is on occasion used to engage and connect present and past staff members resulting in. Contact with long-serving members supports the continuation of organisational knowledge and helps other members, particularly new members build organisational connections. Discussing the past and reflecting on the departmental and organisational journey was viewed as important to Focus Group 1 Respondent 1. Celebrations and anniversaries remind staff as to the longevity, importance, and relevance of a department. This in turn inspires and motivates staff members as they feel included, connected, valued and a part of a larger team.

FG1 R1: *We did have a party on our **110 anniversary** and put stuff on the **intranet** a couple of years ago ... I still invite the previous head physio to our Christmas lunches which is becoming pretty hairy because she is 88 and very frail… And I think it's good to **reflect** back on where we have all come from, I mean our department particularly has been involved with some of the **key** physio practices.*

IR12: *Well, I know when it was 50 years it was quite a **celebration**. So, it helped to, I guess, **motivate** people that, you know, you're seeing people each day, we're providing nutritional support to patients all the time on the wards and it's about making sure it has that **longevity**. Cause if it's been around for 50 years already then, it's going to be around for another 50 years and if you are a part of that **team** who make it work. Yeah. That's **inspiring**.*

Inspiration also drives and motivates staff members to uphold the organisations reputation, whether real or perceived. Interview Respondent 8 suggested that heritage, reputation, and member motivation are linked, and that the presence of heritage encourages members to strive and uphold the standards set by past organisational members. A positive reputation implies the organisation is

trustworthy and successful in its endeavours, therefore the presence of heritage instils confidence in those engaging with it.

> **IR8:** *I think it gives you a sense of wanting to make sure that you have it upheld. Yeah, that's what I'm trying to say.* ***Uphold*** *the standards of the people who have come before you. So, I guess it makes you want to be the* ***best*** *that you can be to you know, not just do the job. I think a lot of people here at RPA and certainly in our department are very, you know, are always striving to be the best in their area. And I think that even in our small profession, we have that* ***reputation*** *that RPA is the centre of excellence. And I think that is all* ***tied in****, it's because you're here in this environment and you know that people before you have done that, and it really* ***motivates*** *you to want to do that as well.*

Other forms of inspiration have emerged due to the presence of built heritage. Interview Respondent 3 noted the presence of heritage offers environmental and organisational visual diversity. These can be categorised as both use and non-use values. The pleasure and satisfaction derived from working within a heritage space, or by using a heritage space for lunch or breaks is a direct use value that was cited as significant to staff member health and wellbeing. It offers connection unlike newer clad buildings which were described as 'soulless'. RPA heritage architecture and art have significant stories behind their development and installation which in their view provide depth of meaning. Each building or statue was designed and built as more than a commodity aimed at maximising economic value and operational output, but with a view to artistry, grandeur and impact. Noting the word 'hand-madey' suggests a uniqueness and authenticity to hospital heritage that further proved attractive to the respondent. They also noted the indirect use value that occurs as a result of walking past heritage on the way to work or viewing heritage from the office window. The aesthetic value it offers to them is significant enough that they divert their walking route to work to ensure they engage with it. This engagement promoted pleasure and satisfaction leading to increased staff member well-being.

> **IR3:** *[O]ur built heritage, it's not just the history part of it, it's the* ***diversity*** *in the landscape, streetscape, the space is really important, and I don't think that gets* ***valued*** *in these kinds of decisions…*
>
> **Moderator 3:** *Can you explore that further? How the space communicates to me or interacts with me as a staff member. Is that what you mean?*

> **IR3:** *Yeah, like spaces that are **nice to be in** and buildings around the street that are nice to walk past. And maybe in a hundred years we will look back nostalgically at glass and metal buildings with cladding on them. But it's hard to believe because, I don't know, it sounds so **emotive** to say that they're **soulless** and we may disagree when they become a nostalgia thing as well, but I don't know, they just, there's a sort of mass-produced abstract quality to the newer buildings in the Hospital compared to the sort of **folksy feel** of the older buildings. And I really **value** them as just things to see and walk past, even if I don't have to work in them. As I said, I always choose to walk this way down that, [indicating the road to the old pathology building] because there's mature trees and these gorgeous buildings and just **aesthetically** it's more pleasant to be around that, yeah you've got a picture of the courtyard there. Yeah, same. Just the scale and the detailing on the buildings and the materials there made of have are a bit more kind of **hand-madey** feeling.*

Interview Respondent 12 further supported the sentiments of Respondent 3 in that engaging with spaces such as the Administrative Building foyer caused them to slow down, relax and reflect on their working environment and day. This led them to release stress related emotions, and to evaluate and better reflect on the activities of their day which again supports staff member health and wellbeing. It also attributes to better role and task outcomes, and by extension supports organisational success.

> **IR12:** *And I think when you know you're coming to and from work all day and you're seeing patients, sometimes it's nice just to stop and **slow down** and walk through that foyer because it makes you just kind of **relax** and just think that the world is actually bigger than what you're thinking in that small way.*

In addition to this, the physical nature of heritage spaces with high ceilings and large double and triple hung sash windows provide an airy and light environment, unlike many new facilities that are built to maximise space and resources.

> **IR3:** *[Y]ou know as a space to be working in, Gloucester House is actually really **lovely**. It's got big windows and high ceilings, well actually like King George [building]. We were really **sad** to be moving out of here [King George V] cause we got put in a really bad building and as a space for what it's for, I think it's actually **really good**. Like for offices and things, it's*

healthier, ***healthier space*** *than where we got put, which has really low ceilings and bad lighting…*

Such spaces like that offered by Gloucester House and its courtyard are rare in the inner city and within large institutions like hospitals. Heritage spaces and gardens offer a spiritual peacefulness that are important to organisations like hospitals that generate a wide range of complex and elevated levels of emotion. Hospitals on one hand generate joy and love in the birth of new babies, and relief and happiness to recovering patients and family members. One the other, produce difficult experiences, extreme stress and immense sadness as patients and family members undergo pain, death and loss. Each of these emotions are also experienced by the staff members engaged in their care. Heritage breakout spaces such as the fountain and jacaranda courtyards at the Hospital assist in supporting staff member mental health by offering opportunities for physical and emotional space and a sense of removal from their workplace.

IR2: *[I]t does remind you you're at RPA when you sit there. So, if you're a new staff member, the view itself and the sort of, the* ***peacefulness*** *and the* ***natural surrounds*** *in the middle of the city is pretty* ***rare****. So, there's a lot of benefit to that. I mean, I look at that new North Shore and even the kids' hospital, I've been numerous times, the gardens are put there, but they're almost an afterthought whereas this is an established garden. So, it is a part of the history, is part of the culture. And even though it's got a number of those demountable and things at the back, it essentially still has that courtyard, that garden and a view that is almost* ***spiritual*** *in its way of being* ***relaxing****.*

In conclusion, interview and focus group respondents identified several benefits in engaging with RPA cultural heritage. Heritage displays, whether text-based, portable artifacts or built heritage, can act as conversation starters that promote discussion and reflection amongst staff members, patients, and hospital visitors. The presence of heritage across the campus, and the historic wall infographics inspire reverence, awe, pride, a sense of belonging and confidence in the organisation. This history and legacy can attract new staff members and boost the morale of existing ones, as they feel celebrated and valued. This in turn generates a sense of obligation and responsibility regarding the continuation of that legacy, and a sense of pride that they are a part of it. Build heritage spaces can specifically offer calming and relaxing environments that assist with mental health and employee wellbeing. Each of these engagement benefits together connect members to one another, to their departments and to the wider organisation. The presence of heritage inspires and motivates

staff offering a visual diversity and supporting a deeper connection to the story of the organisation and to their individual roles at the Hospital.

Exploring Organisational Value

The following discussion explores the core category and substantive theme of Organisational Value. Respondents framed organisational cultural heritage and identified several areas in which organisational cultural heritage presented organisational value. These areas have been concentrated under two key sub-categories as illustrated in Figure 42:

(1) Existence Benefits

(2) Engagement Context.

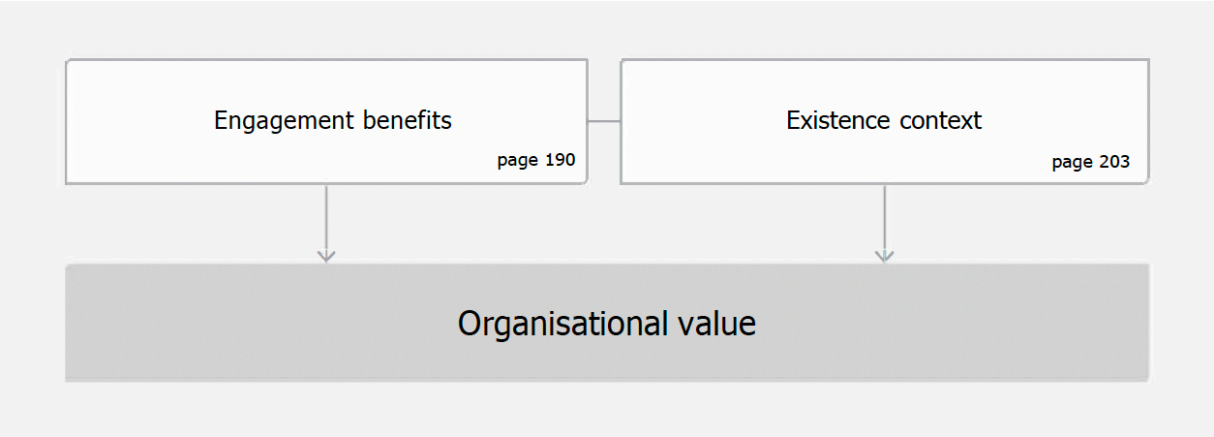


Figure 42 Organisational Value Sub-categories (source: Author)

Existence Benefits

The sub-category of Existence Benefits was determined to primarily offer organisational value and so was merged into the core category of Organisational Value. Existence Benefits encapsulates those aspects of cultural heritage that underpin and strengthen RPA as an organisation as perceived from the organisational member perspective. Key child nodes identified include calming quality, credibility, reputation, permanence, symbolic, tradition, and longevity priceless as examples. The built heritage, movable artifacts, organisational memories, and stories support an image that attracts both new staff and patients to the Hospital. They provide scaffolding for organisational reputation, generate prestige, credibility and provide a sense of gravitas that together strengthen the organisational identity and culture. The heritage built environment also offers a visual variation that promotes staff engagement, mental health and wellbeing and further increases the attractiveness of employment.

Respondents suggested that busts, statues, and artworks located across the campus frame the organisational journey more effectively than was there only built heritage and original architectural features existing. They provide additional strength to the organisational story providing glimpse into various moments in history across the organisation, as opposed to an isolationist glimpse of Victorian era Sydney through the lens of Victorian era architecture. The presence of movable cultural heritage underpins the organisational stories including the myths and legends that support the central identity of the organisation. Interview Respondent 2 felt that the presence of such objects also performs a reminder role, reaffirming that the Hospital was built by people of perceived consequence and 'greatness'. This sits in contrast to those respondents who viewed the busts, portraits and statues as reminders of the division of power and collective exclusion of woman from social, political or economic positions of power within the Hospital and wider society at the time. Further, the dominance of male imagery further strengthens and support the Hospital's educated elite beginnings and colonial connections to the exclusion of other members of the Hospital.

> **IR2:** *[B]y taking them [statues] out of there you are completely removing that evidence that there was ever any* ***greatness*** *there. You're left with a bit of architecture and also the fact that we get a lot of visitors at PA, so* ***visitors, tourists, international delegates****, it means a lot to them. They look at all these things and that is part of the identity. If you took them away, the architecture doesn't tell you about the* ***identity*** *of PA really in terms of the people that that* ***contributed*** *and had the* ***legacy****. So, I think that it is quite important whether you know who they are or whether you understand what they did, I think we need to be reminded of them.*

The presence of material heritage across the Hospital campus performs a reminder role to staff, visitors and patients that reiterates the longevity of the organisation. Respondents noted it as providing a sense of continuity, permanence, and stability. These notions were repeated numerous times during interviews and focus group sessions suggesting such concepts as easily interpreted and acknowledged by organisational members. The Hospital has undergone numerous developmental changes both physically and administratively and has endured and grown throughout the years to expand services and increase levels of expertise. Continuity and permeance underpin these changes and are closely embedded to other themes including credibility, confidence, competence, and trust. Each theme builds on and supports the other to elicit an emotional response aligned to the Hospital's strategic vision of the delivery excellence in healthcare. Credibility suggests the Hospital and its services are reliable and trustworthy. This instils confidence in patients and staff members

suggesting the Hospital and its staff are competent in their services and can be relied upon to achieve the best outcomes for patients. Competency denotes a high level of knowledge, skill, experience, and behaviours which together engender trust. Trust is essential to hospital services as it provides a sense of safety and security in what is already perceived as a contentious and emotional environment.

FG2 R4: *There are lots of aspects of cultural heritage. There's the* ***physical*** *ones and* ***buildings*** *that are old, that can give you an idea of what life is like here at a certain time or give you a sense of* ***continuity*** *or* ***permanence.*** *I guess it just, it has a lot of* ***representation*** *in terms of how long it's been around for. It's nice to walk through the Hospital and have all the* ***old buildings*** *there and the* ***old statues****. It says this is such an old place, and so much has happened here.*

FG2 R6: *The feeling that I get when I come in here now from my experience is a feeling of* ***competence****.*
FG2 R1: *Yes.*
FG2 R6: *The place works. It's clinically probably best in the land.*
FG2 R4: *Sorry, I'm just going to say going back to the main entrance is that again is the* ***confidence****, a* ***stability*** *in stones being here a long time. So, you have a feeling that it works. That it won't shut down, it's been going for a while.*

PFG R4: *People recognise the history of RPA, the tradition of training, the links with the universities, and they've got a* ***confidence*** *that people there know what they are doing I suppose. And I think that would be comforting if I had something bad go wrong with me.*
PFG R3: *I want to go to RPA.*
PFG R4: *I want to go to RPA rather than somewhere else.*
PFG R4: *It's been there a long time, which kind of* ***inspires confidence****.*

IR12: *I think there's that* ***trus****t and I think of my grandma, you know, she trusts the doctor more if they're wearing a white coat. I feel like, you know, you feel more* ***comfortable,*** *and you feel more like there's excellent care here even though I know there is excellent care here, but you feel* ***more*** *like there is that here. Cause there's that history that* ***surrounds*** *it.*

IR7: *Oh, it definitely **inspires confidence**, a sense of **belonging** as well. I think it does. And just in comparison to other sorts of modern buildings, it just has a feel about it that the more modern ones just don't have.*

Moderator 7: *Confidence?*

IR7: *Definitely confidence. Definitely. **Confidence** and **prestige**. That this is the centre of where it's at and that it historically has been. And it's not like as you say preservation for preservation's sake, it's not a museum. This is still very much a working functional place.*

IR10: *So, when I'm **walking** around seeing the **physical stuff**, the buildings and statues, I think about the **stories** associated with that and the **long development** of the Hospital and I think about what's happened in the **past** … I look at the stained-glass windows and the artwork, I look at that artwork every time I walk past. And it's again, I just think who else has walked through this? I draw so much from that.*

Several respondents suggested that new staff members were attracted to RPA in part due to its organisational reputation derived from prestige associated with built heritage environment, the longevity of the organisation and past staff members. Interview Respondent 7 suggested the presence of heritage at RPA creates a 'prestige' and sense of 'gravitas' that is integral to its reputation. The active acknowledgement of the past serves as a reference point and constant reminder as to the perceived greatness of the institution. Further, that these themes when combined create a 'mystique' suggestive of reverence, power and importance which elicit a positive emotional response from staff. They develop connections and therefore stay and remain committed to the Hospital and its services.

IR7: *I think the **prestige** of the place does come from the heritage. I don't think you can separate it out. I think that the name, I think if you were a medical school, there is a whole **mystique** and prestige around working here and part of that is due to its long history and also the fact that its culture and heritage is acknowledged and is in your face. You walk through there and you can feel the history and the heritage in it [pointing to the front foyer image]. You don't get that feeling when you walk into a building built in the eighties or nineties. You walk in there and you think this place has **gravitas**. From an organisation point of view, I think there's a sense, I don't know where it comes from. There's a sense that an older hospital somehow has more **credibility**. And so, emphasising that history somehow gives it **gravitas**.*

Moderator 7: *[Y]ou say then organisational longevity, the history, the memory, it presents as* ***pride and gravitas.***

IR7: *Correct, and you can't* ***buy*** *that. You cannot buy that. It* ***builds reputation****. And that's something that has to be earned. And somewhere like RPA I think has earned that.*

It was further noted that doctors, who often move from facility to facility tend to return to RPA which further supports those notions of prestige and reputation. Interview Respondent 13 suggested that it is a desire to remain connected to the forefathers of the Hospital, and to ensure they are a part of an organisation that exudes great prestige. The roll-on effect being that the 'tradition of excellence' is then perpetuated through the attraction of the best staff which results in a better outcome for patients.

IR13: *If you look at doctors that go from hospital to hospital to hospital to hospital, their technical knowledge goes with them. But what is it that makes them want to* ***come back*** *here? I would track back to say that is it because you are walking amongst people who are extremely innovative because of their* ***forefathers*** *and you know, or is it because it's great to work here? Not sure about that. Is it because your apart of this* ***incredible historical journey*** *– probably?*

FG2 R4: *That* ***prestige*** *will also* ***attract****, you know, doctors,* ***aspirational*** *doctors. People who want to come here to learn from people, which also generates better patient care as well.*

For some respondents the reputation and image of RPA not only attracted them towards employment but also proved deeply inspirational and motivational. Interview Respondent 10 noted an early desire to be employed at RPA and was excited to consider they might add to the heritage of the organisation by becoming a part of its history. They fantasized about adding a 'footprint' thereby becoming a part of the Hospital's continued and growing legacy. Interview Respondent 3 echoed this feeling of inspiration, suggesting that the presence of heritage provides a connection to the staff that preceded them.

IR10: *When I was a student I looked up to RPA as this big hospital and it was kind of almost* ***unrealistic*** *that I would ever get to be part of working there. It was always in the back of my mind. It would be a dream to work there. Yeah. I would be so happy with that. I think because of its* ***history*** *and it's a big tertiary hospital, it's very* ***world renowned*** *and with lots*

of history and just a lot of, I guess in its like clinicians and specialties, it's really high up there. So, I thought if I could work there, I'm getting in pretty high up. Like it's a good, it would be a really good experience being a part of RPA and kind of having a little ***footprint*** *in there somewhere. Becoming a part of the story … it's getting to add, or like being a part of the* ***cultural heritage*** *in a way.*

IR3: *Oh, that sense of like I'm walking where all these forebears walked and I'm carrying on a* ***tradition*** *– it's* ***inspirational****. I'm doing essentially the same tasks that they did, standing where they stood, looking after people with the same aims they had. Yeah, so I guess the sense of carrying on a tradition of service, health care and you know that the principles of your profession and all that stuff that haven't changed since the profession started. So, it's like, Nietzsche's idea that everything eternally returns, and that actually gives everything more* ***resonance*** *because everything you do is actually an echo of multiple times that it's done.*

Tradition is a strong, complex set of behaviours and beliefs. Focus Group 1 Respondent 3 noted that tradition, and the interest in connecting to and supporting customs and traditions can lead people to follow past behaviours in pursuit of deeper emotional meaning and social connection to the organisational past.

FG1 R3: *Look, at the end of the day if people want to go to a big show at the cricket ground they want a comfortable seat, but there are still thousands of them who will trudge up difficult-to-walk stairs to sit in the old members' stand and sit on an old wooden bench that you couldn't say was comfortable because of everything that is part of that. That* ***tradition*** *and* ***interest*** *in that tradition, this is a record-breaking thing, and all around them is the history of the people before them.*

In contrast other respondents were willing to interrogate the nature of the credibility and prestige surrounding the Hospital, questioning how it is achieved and sustained, and whether it is evidence based. Credibility in their eyes is underpinned by the organisational connections to members of the past and to perceptions of organisational excellence that are not necessarily fact based but mythologised realities. Material heritage possesses an inherent power to convey information that may not be authentic or accurate. Due to the longevity of the organisation and the prestige and reputation associated with the Hospital's history, much of the organisational reputational qualities

are self-perpetuating in their view. The presence and continued use and expansion of material heritage further supports these myths, regardless of organisational realities. Further, RPA has a long association with the University of Sydney which is informally known as a sandstone university. Sandstone universities are wealthy institutions known to seek social status and power and that utilise their historical reputation to attract students and build their reputation (Andrews et al. 1998; Marginson 1997). It was thought RPA utilises similar strategies surrounding its heritage, and that its reputation and prestige may not be deserved.

> **IR3:** *There's this sense that the eminent researchers that are famous from the past, that we're associated with somehow gives us some more* ***credibility*** *now because we're somehow building on their excellence and continuing that, you know?*
> **Moderator 3:** *But should it, because we are based on what you said about research being evidence based?*
> **IR3:** *I think the fact that it's* ***prestigious*** *means that you do get a sort of* ***self-perpetuating*** *thing that the prestigious place will attract the* ***top people****. But what I'm questioning is whether an old place should be prestigious just by like as an automatic link. I don't think that's actually the case, but I do think an* ***eminent prestigious old*** *– just the way we* ***think*** *about it – just like old universities are the better universities, the old hospitals are the better hospitals. So, they attract the cream of the crop people because everyone wants to work at the old prestigious places. So, then we do have excellence, but it's, it's actually not based on something that I think is valid. But that's another story …* ***Prestige*** *and* ***reputation****. And I think we do think of older, long established entities as, as having prestige because they're* ***historically continuous*** *and you know, we can point to these eminent people. Some of them line the walls.*

> **FG2 R1:** *I think that* ***perception****, how someone sees the world, whether it's true or not is* ***questionable****. If you collect a large group of people that all perhaps have the same sort of perception. And it's true, people have the perception that RPA's, well Sydney LHD is bigger than RPA, but nobody talks about any of the other hospitals. It doesn't matter that Concord is extremely busy and it doesn't matter that you know, the antenatal department over at Canterbury is much busier than you know the one here, or whatever the case might be. But RPA is RPA and it is a* ***grand view****, because there is this perception of the place, you know, it is the* ***history****, it's the* ***stability****, it's the* ***respectabilities****, all these things. And it goes together with the Great Hall at Sydney Uni. Whether they're eighth in the world for their humanities*

or the first, it doesn't matter about that, you know, that Great Hall carries with it a lot of ***power****. So too the front of RPA carries the same, I think.*

Interview Respondent 13 further supported these notions but interestingly suggested they understood the psychological response to heritage at RPA. While they did not believe that the Hospital excels in all the services it provides, the presence of heritage implies a tradition of excellence that elicits an emotional response they found confusing.

IR3: *Oh God, I don't even know the slogan. A* ***tradition of excellence****. Yeah. So, it's like we're built on a* ***foundation*** *of excellence and* ***greatness*** *and that's enabled us to* ***jump off*** *from that and continue to be excellent… So, to me it's sort of, it's* ***counterintuitive*** *but it's still a thing that people do* ***respect*** *an older institution that has past associations with greatness and somehow there's an* ***implication*** *that we have, you know, built from that. And that enables us to continue with excellence even though I don't actually believe that. I still kind of ...* ***emotionally*** *I can respond to that feeling and I think all that about, you know, but it's a fair question.*

While that emotional response is perceived to significantly underpin the organisations reputation and prestige it also serves to positively support staff member health and wellbeing, and by extension staff retention and loyalty. Respondents felt that maintaining built heritage and heritage environments ensured the development of personal connections to the organisation. Loyalty is a central component that underpins hospital-staff member connection. Loyalty is a strong word that engenders trust and respect and is suggestive of an attachment and allegiance to the Hospital. These characteristics then support the development of organisational capital through the presence and use of heritage.

IR4: *I think just the value in the cultural heritage of the Hospital is how it provokes emotion and an* ***emotional reaction*** *and* ***emotional connection*** *to the Hospital. Like what drives people to come here, stay here and continue working here and wanting to see the Hospital to succeed and improve. And because I think in* ***combination*** *with the environment and people you work with in the management of the Hospital, like all those kinds of things help with staff* ***satisfaction****, patient satisfaction and achieving good work. Yeah, I think because the work like as a midwife and nurse is quite* ***emotionally*** *and* ***physically draining****, I do appreciate the sort of* ***environment*** *and* ***feelings*** *around the Hospital that make me feel*

***connected**. Cause if they weren't there, I'd probably leave or go find somewhere else that makes me feel more connected, but that's in combination with like other things as well, like the people that you work with, the management of the Hospital. So, it's kind of all their things together. That's what makes you want to stay or makes you feel **drawn to stay** if times are tough and you thought that other places were better than probably move on.*

IR5: *But I think there is **loyalty** to the institution and partially because of its **age**. I don't think with the Northern Beaches Hospital that's just opened, it's gonna take a long time to build up that kind of **capital** with its staff that I feel loyal to this institution.*
Moderator 5: *Interesting that you've used the word capital. People are part of the organisation, but we build that capital through time, that's really important to hang on to?*
IR5: *Yes. And it's what makes, I think staff loyal at a **personal level**, not just the professional level … here it's easy to feel loyal quickly because you've got that **long tradition** that is apparent around you because of the buildings and so on. You know, you're working somewhere that's existed well over a hundred years and has a **long tradition** and traditions in our **motto**.*

The presence of heritage was further identified as organisational capital in that it offers an aesthetically pleasing environment providing visual interest and pleasure, and a sensory stimulus. During discussion surrounding the 1882-built front foyer, respondents described the environment as 'beautiful', 'stunning', 'warm and welcoming' and 'quite special'. Heritage was perceived by respondents as art and art stimulates joy, reduces stress and anxiety, and provides inspiration. While Interview Respondent 11 acknowledged they knew nothing regarding the history of the front foyer, they acknowledged it provided a unique feeling that made them 'feel good', and that they emotionally responded to the space. Such a response is more associated with the artistry of the heritage material as opposed to heritage significance. Focus Group 2 Respondent 7 noted an inexplicable feeling associated with visiting the front entrance of the Hospital describing it as an 'aura'. They experienced the space as a calming environment and of the space was one that provided a calming and safe environment.

IR11: *I think it's quite beautiful. I don't really think about where it's come from. I just know that it's probably an original building that's been well maintained and restored. I like the feel of it. I **feel** like I'm walking into something that's really quite **special** and **beautiful.***

IR3: *And I really value them as just things to* ***see*** *and* ***walk past****, even if I don't have to work in them … The other is because they're the real thing. They're* ***unique*** *and* ***irreplaceable****. So as actual items of history, they're* ***special****.*

IR12: *all the cultural heritage around you actually feels quite* ***welcoming*** *and* ***warm*** *when you walk in.*

IR6: *[A]s you walk in and you think that's actually* ***quite beautiful*** *and it is, it's really nice. The lighting as you walk through the Hospital in the older part, of course there's still some of the beautiful cornices and stained-glass windows – the door frames, everything to me. It's just part of that* ***beautiful flavouring*** *that that makes it RPA.*

IR7: *Well, you walk in there and you think this place has* ***gravitas****. Definitely. And then when you then cross into the modern bit, it's just such a beautiful* ***juxtaposition*** *of the old and the new. It's really* ***stunning****. There's not that many beautiful old buildings in this condition that are freely open to the public and that are still actually used. It's not a museum. It's still a* ***living, breathing, functional space****. That's an* ***attraction*** *to some, at least to me anyway.*

FG2 R7: *There's an* ***aura*** *about coming into this place. And I've had my experiences cause you know, I've had plenty of experiences. I've always* ***felt safe*** *and my family we're always* ***relaxed****. My being here, you know, I have felt safe in myself … and it's just a, it's hard to explain, but this hospital has a, it's got a* ***feeling*** *about it and I can't explain it.*

When discussing possible alterations to the front entrance hallway Focus Group 2 Respondent 9 noted that more than heritage would be lost should it be changed. The 'feeling' of the space would be lost, which they suggested represents more than material objects. They argued that material heritage in situ resonates an authenticity and uniqueness that cannot be replicated. Moving, changing, or replicating artifacts and spaces alters the dynamics of the relationship between the organisational member and the space. Interview Respondent 3 discussed the presence of a particular unique 'energy' that exists in spaces such as the front hall. To suggest a space or material object has energy is to suggest it possesses qualities or attributes that perform a task and that are active, and not static. In their view then, heritage material embodies a collection of attributes that elicits a response from them and that offer organisational value.

FG2 R9: *But you can't **change** that feeling when you walk through that [indicating front foyer image].*

Moderator FG2: *You can't replicate it?*

FG2 R9: *No, you can't **replicate** the feeling, sorry, no. The issues are fixable. They are fixable but you can't, you can whitewash it but then you **lose** a lot more than just heritage actually.*

IR3: *But to anyone who's interested in history there's some kind of special **resonance** that an object has when it's actually the real deal from a long time ago and it's like a little **time capsule** and it's, you know, you feel like you shouldn't, if you touch it, you'll be getting some kind of **special energy** from it. And I mean I think there is **value** in it being in the very room where it was originally, as I was saying before, it's like the sense of this is the actual thing. You could make a replica of some historical thing and it's not the same. And so, you've **lost** that. If you've had to move it, you've just got the photos of what it was like and so people can still see what it was like. But you've lost that **magical energy** you get from the real thing.*

Respondents argued that altering the integrity of heritage spaces and removing portable heritage as damaging to the identity of the organisation. The presence of the busts and portraits across the campus support and underpin the organisational story, which in turn engenders gravitas and prestige. The people who built the organisation are significant to the story and constitute a large part of the organisational identity. The larger legacy associated with the organisation is removed or altered when portable heritage is removed, and organisational spaces modernised.

IR2: *[B]y taking them out of there, you are completely **removing** that **evidence** that there was ever any **greatness** there. You're left with a bit of architecture, and also the fact that we get a lot of visitors at PA, so visitors, tourists, international delegates, it means a lot to them. They look at all these things and that is part of the **identity**. If you took them away, the architecture doesn't tell you about the identity of PA really in terms of the people that that **contributed** and had the **legacy**. So, I think that it is quite important, whether you know who they are or whether you understand what they did, I think we need to be **reminded** of them. Otherwise … you lose that, that **responsibility** of what the identity brings with it.*

The act of protecting and displaying cultural heritage is suggestive of the values held by the organisation. A perception is created that implies if heritage is respected and valued, then the history of the organisation and all its components are valued, which includes organisational

members. Respondents further noted that the active use of heritage implies that the Hospital's history and journey is respected and valued by management and leadership teams, and that protection and preservation are not superficial responses forced by policy instruments or state mandated legislation. This then has a roll-on effect impacting belief systems and behaviours across the organisation strengthening member engagement with organisational values and ultimately organisational culture and identity.

> **FG1 R3:** *So, I think the complexity of this is that places that **value** the **past** value the **present**, and places that don't value the past by and large don't value the present either – they are very utilitarian. And if you have a utilitarian view generally then that transfers not just from the buildings but from the disposability of the staff. You know the lack of care of context of someone's working life, what the context is the patient and their family. It's i**ntertwined** in a very complex way in people's minds as well.*
>
> **IR2:** *The fact that there is a **museum** here for a start just shows that actually the organisational, cultural heritage is **valued** and the importance of it is recognised. And not just in a, you're not just paying lip service to it. It actually is important. And the fact that there are displays that there are efforts to get some of that out there and to get people **interested** in it. There are publications, there's the work that you do, there's the historical stories. There's the fact that you do have, you know, the **busts in the foyers**. … So, there's not as many institutions that have, are this old, but I think it's very clear in the work that's just been done on the facade out front, spending the money on that and **restoring** it and doing it properly shows that the history and organisational culture is **valued** and **respected,** I think.*
>
> **FG1 R3:** *But one of the things that gives a place its **reputation** is what their **values** are, and whether they value contribution or gloss and floss, and by and large places that actually value their heritage look a bit beyond the **superficial**. And I think that people do get that sense.*
>
> **IR5:** *… means that I can see that RPA **appreciates** its cultural heritage, which helps me further my **connection** with the Hospital. The fact that the Hospital and presumably the Ministry of Health **values** the heritage, the cultural heritage, it **reinforces** for me that value. … I don't think 'Oh, why am I valuing this when those much higher up in the chain aren't?' So, it's as I say **reassuring**.*

Interview Respondent 6 suggested that the 'historical backdrop' of material heritage greatly impacts and ultimately frames staff member behaviours and organisational culture at RPA. Describing it as part of the 'fabric' of the organisation suggests heritage as a central component and integral part of the structure and function of the Hospital. It underpins and influences how staff members engage in teaching, research, innovation, and everyday core operational activities. It further supports organisational values that Interview Respondent 2 identified as deeply embedded. The name of RPA itself is weighted with expectation and responsibility.

> **IR6:** *[I]f you look at it from a cultural perspective, yes, there's organisation and there's group and then there's individuals and, and how do they all interrelate? So, from an organisational perspective, yes … it is* ***heavily influenced*** *by that* ***historical backdrop****. And so, it doesn't matter which department you go to, there is intertwined research, teaching clinical work. And it's just, as I said, part of our* ***fabric****. It's the way we do business, and as you know it's been this way from the start. So, it affects how people think, it affects how they're supporting younger colleagues coming into the environment. Therefore, how they* ***behave****. It takes on that sort of mentoring role for the more senior staff. There's that sort of* ***pride*** *in what you do because you're part of something bigger that's got* ***credible*** *history behind it. And I do think that's what influences the* ***culture*** *at PA to the extent of the individual and how they* ***behave****.*

> **IR2:** *But then when I started going to other bigger hospitals, I realised, no, that's* ***RPA-think****, that breadth and depth, you need to be the best you can be because we're at the cutting edge and it's* ***unspoken****. But you'd go to the meetings, I was often on different committees for different things and there was always the notion that you need to be a value to the organisation and you need to be* ***head of the pack****, the* ***best in your field****.*

In conclusion, study respondents noted several key benefits to the existence of organisational cultural heritage. Respondents suggested that the preservation and use of heritage promotes an internal and external perception that the organisation values its past. The flow on effect of this is that in the organisation valuing its past, it may then also value its staff members. The presence and use of heritage also serves as a reminder as to the longevity, continuity, and permanence of the Hospital. This then supports hospital credibility and generates a gravitas that inspires confidence,

trust, and a sense of security amongst patients and staff members. This security is further supported by landscape and organisational space aesthetics and diversity. Heritage spaces were said to offer a calming and relaxing environment that supports positive mental health and wellbeing. There was however contention as to whether the presence of heritage offers an accurate representation regarding the Hospital's reputation. Respondents suggested the presence of heritage might falsely underpin the Hospital's credibility and reputation supporting an image that is not evidence based or an accurate reflection of the Hospital's qualities or values. Further, that RPA heritage offers artistic value that influences organisational member behaviours that are not based on health care best practice, but are superficial emotive responses to heritage as art.

Engagement Context

Several cultural heritage engagement contexts emerged during interviews and focus group sessions that were identified as primarily offering organisational value so were merged into the core category of Organisational Value. Context in this sense is what Duranti and Goodwin (1997) refer to as objects associated with a focal event, and that focal event leading to a moment of engagement. The following explores the various ways in which organisational members described interacting and engaging with heritage at RPA, and the outcomes associated with this engagement.

Respondents noted that several departments utilise organisational history in their orientation packages to familiarise new staff with the history and heritage of the Hospital. Interview Respondent 3 identified a self-guided departmental training tool that utilised small amounts of historic information to further new staff member departmental background knowledge. They noted however that in their view the historic information included was underdeveloped and should be extensive. They demonstrated disdain towards staff with limited historical knowledge of the organisation highlighting the importance of new staff members being able to recognise the prestige and significance of employment at RPA. RPA was again framed as an elite hospital and identified as a career high point in a healthcare workers career.

> **IR3:** *When we have new staff members start, part of their orientation is a* ***self-guided hospital tour****, which sometimes if there's a free person, take them on. And it does have a couple of little bits of history.*
> **Moderator 3:** *The self-guided campus tour?*
> **IR3:** *No, no, so they have to find things that they'll need to do in their job. So, find the pathology lab. This is where you go, and you have to put in a thing. And then whatever ward*

*they've been allocated, they have to go there, and they **walk around**, and it does have a bit of stuff about this is the original blah blah and you know, this on this site was or something else. Has a few little bits like that. But if I'd been in charge of writing it, it would have had a lot **more** because I just think, you know, you're **working** at RPA now, you know it's important to know that stuff. Yeah. Imagine being **oblivious** to some of the things that have been here?*

Alternately, nursing and midwifery orientation packages contained a more complex and detailed history of nursing at RPA. As a result, Interview Respondent 4 positively engaged with the historical material noting it highlighted to them the significance and status associated with their role within the organisation. This suggests there are two tiers of value surrounding employment at RPA that require recognition. The first being that of the base value in finding employment in healthcare, and the second is recognising the weighted nature of that value in that they are employed at RPA. That respondent noted an increased sense of pride and connection as a result.

IR4: *I guess I particularly focus on the nursing and midwifery side of the cultural heritage. I know when I started here, I got a rundown of when the nurses started and where they were **living** and what they were **expected** to do at the time.*
Moderator 4: *So, you received an oral history?*
IR4: *Uh not, no, I got a **package of information**. So, it gave a little **timeline** of when the nurses started and how they come out of the Hospital and their roles and how it progressed over time.*
Moderator 4: *What were your thoughts on that?*
IR4: *It was interesting because when I did midwifery as well, so 2017, they also gave a little bit of a rundown of the midwifery services and the women and babies [building – KGV] and how it came about. So, it is **interesting** to learn it I found.*
Moderator 4: *Was their value in doing that or could you just have gone without it?*
IR4: *I mean I guess I could, could've just ignored it, but I think there was **value** in it because I don't know it, I think it kind of **instilled the importance** of the role. Like, I don't know, not that I had to uphold like a great standard, but I just, that kind of made you **proud** of being at RPA and then wanting to **continue** that forward. No, it definitely helped me feel **connected**, I guess.*

The Dietetics Department were further identified as specifically storing their heritage material within their department preferring not to donate it to the RPA Museum. Paradoxically, one respondent

noted it was not used or engaged with in any way. They interpreted the preservation and storage of heritage material as an emotional response to the materials age and as representation of the department's journey. Non-use value was determined from its existence. They had not questioned or investigated further as to the rationale behind the presence of the collection but just accepted it as an aspect of their department.

> **IR3:** *Our department library has a few **original documents**, like we have the **diet manual** that was originally used when the first dieticians trained in Australia at RPA. Just a few, yeah, just **relics** of those days, which we've kept just cause, you know, they're **old**, but I don't think anyone in the department really does anything with them. We just have them.*

Alternately, when discussing a new departmental history wall infographic, respondents noted an increase in engagement with that department's history. Respondents stated that the Renal Department's history wall infographic rapidly became an active tool of engagement amongst both internal renal staff and external members. They noted staff members were found enthusiastically discussing it which strengthened departmental identification. Further, that patients and visitors to the departmental waiting area were found to actively engage with the information on the wall which was suggested to inspire confidence and trust in the service.

> **IR12:** *I think if they [new staff] walk in and see that there that is their **history**, it might prove really **valuable**. I think what happened when people found out about the wall, everyone wanted to go down there and have a **look at it** and then everyone kept **hearing** about it.*

> **IR13:** *I think having a history wall like this is **fantastic** because you can say, you know, in 2019 we've moved from X to X, but before that we were over there or that building existed. I think people who are **interested**, and I think, you know, you're getting people who are older, the baby boomers are interested in this type of stuff. This is great for people to actually **learn** about the pioneering stuff that we do here. **I love it**.*

Other key moments of heritage engagement were identified as occurring at staff events and celebrations. Heritage objects were on occasion actively used during both smaller departmental celebrations and larger organisational events. Some respondents were noted as having detailed and complex understandings of their departmental histories. Heritage imagery and documents were produced to celebrate milestones amongst departmental members and were digitally disseminated

to further engage non-departmental staff. Such behaviours highlight the pride felt by some respondents surrounding their respective healthcare fields. That pride inspired them to engage others in celebration and recognition.

> **FG1 R1:** *We did have a party on our **110 anniversary** and put stuff on the **intranet** a couple of years ago. So, the department was set up with the first head physio being a doctor, and one of the guys in the department is very interested in First World War history. Dr Roth I think of German ancestry, he was the **first physio** here, and there were some massage practitioners that were physios, our registration didn't start I think until 1949 I think or 47, and it's very interesting because of the doctors that are here I guess … we did a thing in the physio department and invited a lot of the staff that had been here before, and we had up a lot of the **old pictures** and **things**.*

The Kerry Packer Education Centre, the main educational facility at RPA contains and displays heritage that is both actively and passively engaged with by both staff and non-staff when attending events or training, or when used as an hospital access route by staff. The hall and RL Harris Heritage Room break out space are areas that contain permanent heritage paintings, photographs, plaques, and stained-glass windows. All significant RPA healthcare achievements are celebrated in the facility, and visitors to the centre walk past or congregate where heritage imagery is displayed and can be contemplated during events. These heritage elements often provide additional depth to the event in progress by reminding attendees that medical best practice and numerous healthcare 'firsts' have occurred at the Hospital and that, as suggested by the event they are attending, and the surrounding environment, will continue to occur. Such moments capture and highlight the notions around organisational memory, material heritage and emergent heritage. Focus Group 2 Respondent 4 interpreted the essence and identity of RPA as 'history and future' expressed through the presence of material heritage, new infrastructure, and healthcare innovation.

> **IR8:** *So, you know, I think the nicest thing is walking through the main foyer, as you walk into the main hospital and you see all the **old photos.** And the **stained glass** and you know, there's some really lovely **photos** in there of nurses and the old wards and so on. So, I think for me, it's about being visible, for it to be **visible**, for it to be **recognised** and **acknowledged**. That's what makes it **important**.*

IR13: *[A] lot of our **celebrations** stem from our **history**. So, I think, you know, as you walk through the **foyer,** you're very aware of how old this place is and therefore what's come behind. It has **prestige or gravitas** about it. So, you know, we celebrate all of these **milestones, achievements**. We did the **first** X, we did cochlear, we did this, that's all stitched in history I suppose. And it **follows you** through as you walk.*

FG1 R3: *I think the **challenge** for us is to actually make it come alive, you know what you're doing with **displays**. People stop, they look, they think there was a time when that's the ways things were done, and we've come a long way etc. etc., but they also think about what sort of **problems** people were dealing with at that stage... That's certainly been the case down in the Kerry Packer [Education Centre]. Even just a few weeks ago I saw people with **mobile phones taking pictures** of the big set of notes that are actually in those images because it has some of the **nursing instructions** and things, and the available therapies. So, there is interest there that doesn't need a lot of scratching before it becomes a **desire** to read more.*

IR3: *I love the **physical displays**. I reckon there should be more of those. So, you walk by, for example, the old one in the Nurses' Home that has the **stories** of the nurses. Yeah. I love that. 'Oh, look at all this nursing stuff, this is really cool', and I'll read all of it.*
Moderator 3: *That engages you in the history.*
IR3: *Yeah. And I think with the nursing stuff particularly nursing has changed so much since then and **highlighting** that at the same time makes you aware of what hasn't changed about nursing.*

FG2 R5: *We know in our area, it's like a **living museum**. You've got the story there and you've got the honour boards. You know what I mean? It's like a **mini little story**, I think that's how RPA is. You've got the heritage and then he's [indicating moderator] filled the campus in with all this **information** and then you walk into the new auditorium and that's, I think RPA. It's like **history and future**.*

Interview Respondent 13 further described actively attempting to educate and psychologically influence new staff members through engagement with organisational heritage spaces. They used material heritage as a central focus from which both their pride and enthusiasm were demonstrated, and their identification with the organisation openly highlighted to new staff member members. Hospital executive management were further suggested to intentionally include heritage

information during meetings and electronically delivered memos. References to past moments of change, or healthcare goals or achievements were supported and strengthened by the inclusion of historic moments, which can be interpreted as attempts to control organisational culture and identity.

> **IR13:** *You know, whenever I **orientate** new people, I'm always extremely **proud** to tell them this is what this used to be, or this is what that is. You know, 10,000 people **walk through** this foyer and we can't put high-tech in here because of x and, original lead lights, etc., etc.*

> **IR7:** *And heritage is also used in a more **intangible** way, its history is referred to quite frequently in some of their [executive management] **rhetoric** about what we're doing or whether we're trying to **improve** our service.*

Digital representations of organisational history and heritage are uploaded by museum staff to the district blackboard on the intranet (see Appendix E). Interview Respondent 1 suggested time limited, accessible historic media such as the 'Did you know…?' campaign is easily engaged with finding it 'fascinating'. Such articulations suggest digital heritage media provides insight and by extension meaning to the presence of material heritage across the organisation. Other respondents viewed the flyers as important strategies to build and support positive organisational culture amongst staff members.

> **IR1:** *Yes. I've seen that, which I thought was **fascinating** and it grabbed my attention. I definitely read it. So, I think things like that as well is, is sort of that **time limited** sharing of a, of a **unique** piece kind of thing. And then taking that down and putting the next time, limited, unique piece kind of thing. So, it's really **accessible**, really visible, really easy for people. And it's just that **interesting human story**.*

> **FG1 R1:** *And as I said one of the guys in the department is **interested** in history, so I always **print out** those things you do [RPA Museum: 'Did you know…' campaign] on the intranet and give to him. He's actually started **passing them around** the department, so they are all very interested in them. Yeah, I think it can **influence behaviour** when you reflect back on some of these things and can **influence** the **connections** in how people work together.*

Other respondents noted that the museum was actively used by staff as an educational tool to engage new staff and as a space for patient respite. Several respondents were noted as taking staff to visit the museum upon commencement of employment to both instil a sense of wonder in them surrounding the Hospital and its long history and to introduce them to the technology and medical processes of the past.

> **PFG R3:** *I **love** the museum. We take our **nursing students** to the museum. No, I think it's good. It's got a lot of things in it that bring back **memories** and just shows the **history** of RPA.*
>
> **FG2 R9:** *[O]ver the years I have always sent **volunteers**, **new staff** and even **patients** that are sick with their loved ones by their side for months at a time. One of the things I say to them, just go over and have a look at the museum and they **love** it. That it, it's not just talking about RPA, it's actually a place where people like that can go and visit and **relax**.*
>
> ***IR13:** Yeah, oh god, yeah, you should see their **faces** sometimes, when they see those viewing windows up high in the operating theatre. Once you say 20 student nurses or whatever would watch you give birth, poor woman, they all go 'no way'. It's so **important** for them to **understand** this is how we did it. The it seems real, well it is real and not just a story from some old nurse.*
>
> **PFG R1:***I think what the museum also shows us is how medicines evolved. And that's what I think is the most **interesting** thing. You look at all these things and you think how on earth did people survive surgery, but they did.*
> **PFG R4:** *Yeah that's right. Like that iron lung. I love **seeing** that, wow, I'd **heard** about this negative pressure…*
> **PFG R1:** *I know, so do I, but can you **imagine** kids spent months and years in iron lungs.*
> **PFG R3:** *And I **wonder** do they get pressure injuries…*
> **PFG R1:***That's what I think about that as well, do they turn them?*
> **PFG R2:** *They would have turned them because that was big in those days.*

Several respondents viewed and described heritage as framed from within their personal life experience and not exclusively from an organisational or professional perspective. RPA is a long-established anchor institution within the local community and as previously discussed, holds deeps connections to the University of Sydney. Large public hospitals like RPA provide extensive services

that community members personally engage with throughout their lives either as patients or as family and friends of patients. Respondents explored those interactions, connecting the heritage of RPA to their personal stories and family heritage. Family heritage is a central component of individual identity providing deeper connections to self through understanding where an individual comes from, what their family have experienced, what their values are, and ultimately what makes them unique. These components can impact on aspirations and motivations, framing how an individual perceives the world around them. Consequently, the Hospital and its material heritage can be viewed from within a subjectively developed heritage lens. Their personal stories are both embedded with and derived from histories associated with RPA.

> **FG1 R2:** *I come to this whole cultural heritage angle I guess from a **personal perspective** of what my interactions have been with this place. Not only as a local resident here for the past 30 years, this has been my **local hospital** … in many ways this is an institution for the community. If you think of all of the people of the inner west who were born here and have died here and were sick here and were treated here. But for me the personal connection is the fact that my dad was a medical student here in the early 1940s, I think he was on one of the first residents in this building [indicating KGV] when it opened. Me and my five brothers were **born** here, and my two kids were born here, and that I have been **working** here for the last 23 years. So, it's very much framed for me across that. That's probably a 70-year **family connection** to an institution. And that's the kind of framing with which I view cultural heritage.*
>
> **FG2 R6:** *It comes from part of your **family heritage**. Yeah. My kids were all born in this building, some of my grandkids were born in this hospital. I've been attended to in this hospital. My wife's been attended to in this hospital and our grandkids, you know, things broken and appendix out and stuff.*
> **Moderator FG2:** *It's a part of your personal story?*
> **FG2 R6:** *It's part of our family heritage. Yeah.*

Family stories can provide the context for the initial development of a connection to the Hospital. Interview Respondent 11 noted that family and older generations with pre-existing relationships with RPA inspired the construction of a connection for them. Without significant knowledge of the organisational history or material heritage, family and friend references to their experiences at RPA generated an emotional response that may not have otherwise occurred. They were influenced to

believe they were now a part of something significant. This builds a connection for the staff member who then can identify more easily as a member of the organisation.

> **IR11:** *Definitely. Like you said, nursing's a big thing here ... I told another person, I told her I worked at RPA, they were like 'Oh my God, I did my training there and we used to stay there in the* ***nursing quarters'*** *and stuff. Yeah. I was like, 'Oh, I didn't know that.' I found that* ***really cool*** *… I know that like my dad said he was born in* ***KGV****, so he* ***tells me*** *about that. And then my grandpa as well. I feel like whenever I talk to people that are older, they get very* ***excited*** *that I work at RPA because they know that it's been around for* ***ages*** *and it's a huge hospital. So, I* ***feel special****.*

Retired staff were also found to assist younger staff in the development of connections to the Hospital through story telling. Focus Group 2 Respondent 4 described Graduate Nurse Association Members regaling staff with stories of buildings and built spaces long demolished. They identified how strongly these ex-staff members identified as a member of the Hospital, celebrating its history through the presence and absence of material heritage.

> **FG2 R4:***I mean sometimes I think … because we work in the Kerry Packer Education Centre, well for example let's talk about the old nurses coming [Graduate Nurses' Association yearly convention]. One thing that they* ***enjoy saying*** *is what I did here, they also enjoy and still have a* ***connection*** *to the place. They're the only people that do* ***remember*** *those buildings so they can go 'I remember when there was a beautiful building there, it was wonderful, let me tell you all about it.' That's their connection to the place that's still here. You know, we're not going to have that connection [indicating other staff member] because the building's not there, but we've had an old nurse tell us about what happened, so we've got some of the history. So, there are still aspects of heritage that are different than just the* ***physicality*** *of the* ***stone structure****.*

Respondents further noted that current staff member and patient stories were often key to the establishment and further development of hospital-staff member identification. Stories helped provide a background narrative and emotional response to hospital material heritage that was preserved and continued by staff members that in turn led to an increased level of heritage engagement and a deeper connection to the Hospital.

> **IR6:** *So, the insignia, the emblems as you walk into the main entrance to RPA on the left, you know, is it courage, love and wisdom, those sorts of terms that the nurses see as they would walk in. It's a **story** I heard from an **old nurse** actually at a forum once, and it stuck with me and I now do it. Every time I walk in, I look to the left and I just **remember** that. So, there's a plaque and they were instructed at the time to repeat those sort of **core themes** with the work that they do. But it hit home for me in the sense of a building that's **live**, it's **organic** in that sense. So, it's got these sorts of **messages** all the way through the tiles as you walk in, that sort of **grandiose** feel that you could see a hundred plus years ago…*

Patients and visitors that positively engage with campus material heritage were suggested to help influence the development of organisational member connections to the Hospital. Interview Respondent 12 described how witnessing visitor excitement over architectural heritage spaces inspired a feeling of pride in the Hospital and in their employment. Visitor behavioural response to heritage performed a reminder role to that staff member who had become removed and disassociated from the nature of their working environment. They became reconnected through the excitement of others which generated pride and re-established their identification with the organisation.

> **IR12:** *I was walking through the other day and there was a lot of **people taking photos** of things and they were there with their **family members**, and they were saying 'Oh, I can't wait to show such and such back home. Look at the **lead lighting** here and look at all the history that's here.' And I saw that, and it also made me feel like, 'Oh yeah, that is actually really good.' I work here. I felt **proud.***

In conclusion, study respondents noted several key engagement contexts in which they interacted with RPA cultural heritage. Members actively engaged with heritage by seeking it out to walk by or sit near for aesthetic pleasure, and for mental health and wellbeing. Members also actively sought out heritage for the purpose of introducing and engaging new staff members to the history of the Hospital in attempts to influence their perception of the Hospital and their role in it. Personal family stories and stories of others assisted in the development of organisational backstory for new members when there was no prior connection. During organisational and departmental celebrations objects and histories were interpreted as being utilised as tools of remembrance. Installations and displays occur sporadically during key celebrations and as ongoing departmental feature displays. Wall historic infographics and digital history communications offer modes of engagement as long-

term educational and informational tools, and as time limited objects of interest. Additionally, the RPA Museum acts as a central repository and key mode of engagement for patients, visitors, and staff members.

Exploring Management Complexities

The following discussion explores the theme Management Complexities. Numerous complexities were identified surrounding the presence of cultural heritage at RPA. These issues have been concentrated under two key sub-categories as illustrated in Figure 43:

(1) Operational Challenges
(2) Financial Implications.

Participants made numerous references to the challenges faced by a health care facility like RPA regarding the presence, use, management, and costs associated with organisational cultural heritage.

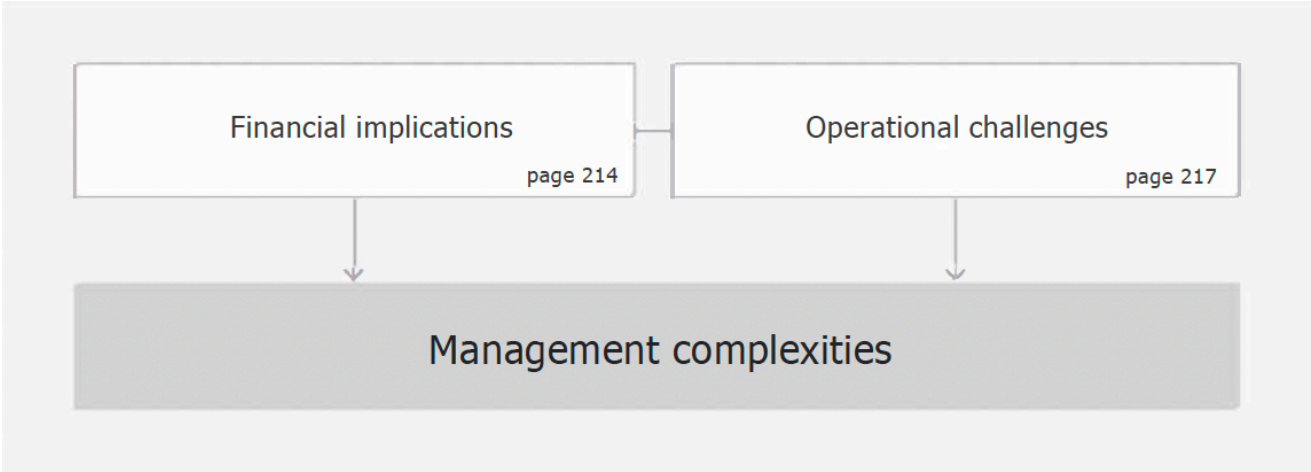


Figure 43 Management Complexities Sub-categories (source: Author)

Financial Implications

The first sub-category that emerged from the data relating to the theme Management Complexities was that of Financial Implications. Financial Implications encapsulates the monetary issues associated with the continued storage, preservation, maintenance, and refurbishment of organisational cultural heritage.

A hospital's primary purpose is to provide health care, and some respondents questioned whether money spent should be primarily focussed towards meeting this objective and not that of the collection and storage of heritage material. Further, that other organisations are better resourced

and specifically tasked with the management of movable cultural heritage. As a result, there is a clear tension between needing to recognise the value of heritage, acknowledging the emotional response to heritage, and pursuing and supporting effective healthcare outcomes. Most decisions within a healthcare setting are framed around the financial implications and healthcare outcomes of that decision and so some respondents suggested heritage must provide a use value to be considered an important and viable component of the Hospital.

> **FG1 R2:** *I guess they [RPA Museum] are a great resource for people doing research. But these things could be sent off to state archives and possibly be **better cared for**, and as our **primary purpose** is health care, it's a fair question. Should **dollars** be spent on it?*

> **IR13:** *[I]t's hard to quantify that **financially** though. You can see there's an emotional response to this, it's a **non-use value**. I know it's great and it's lovely and it's really, I really care about it. But the **primary purpose** of the organisation is something other, right? So, you've got to balance the **tension** between that. So, you have to then say, what's the value? What's the **core value** in keeping this stuff? We have a primary purpose to consider first … Sadly, this is all **weighed** against the dollar.*

The practical implications associated with space limitations, building functionality and the responsibilities concerning the use of taxpayer money to support the continued presence of heritage were identified as impacting staff member perceptions of value. Interview Respondent 7 stated there is a resourcing limit to which hospital heritage will be supported which suggests there is a tension surrounding the identification of organisational responsibilities. Central to that tension is that heritage perception of value is subjective, and that heritage use is key to that perspective. If heritage can be adequately and appropriately used, then its value perception increases. If it can't then it is perceived as a financial burden to the organisation.

> **IR7:** *I think when you're in a very **cramped campus**, there are always **practicalities**, I suppose you end up **prioritising** them. So, the 1880s blocks would be your first priority. And you know, if the restoration **costs** are just **too much, too high**, I suppose you gotta be **responsible**, it's taxpayers' money. How much do you **spend** and how much is **too much**?*

> **IR9:** *I think it always unfortunately comes down to **money** and how much people are **willing** to **invest** to preserve the building. But also to make it more **functional**, and the better*

*capacity offered. It must meet these **needs** first. Money can't be endlessly **wasted** on constant repairs and so on.*

Buildings such as the 1936-built Gloucester House, the first Intermediate Hospital (public–private) built campus, is in poor condition. Although heritage listed, the building's ongoing presence and preservation proved contentious. Respondents commented on the recurring cycle of repairs that Gloucester House has undergone during their employment. Interview Respondent 8 suggested such management strategies were wasteful and that the practical implications of effective healthcare management outweigh staff member emotional responses to maintaining build heritage. The current state and use of the building suggest it is not highly valued. This notion is however challenged by other staff who acknowledge that Gloucester House was built as a hospital and not an administrative centre for offices. Interview Respondent 13 suggested that based on past behaviours, ongoing financial support might be limited. Interview Respondent 6 noted that balancing the ongoing cost of repairs of Gloucester House against its use value was a challenging exercise, and one that ultimately couldn't be justified.

IR8: *And you know, ever since I've worked here, it's just been a bit of a **mess**. It's got concrete cancer and people come and go and they try and do something with it and so on. **Can't** keep doing that, regardless of **people's memories**.*

IR13*: Look, Gloucester House already makes me **extremely frustrated** from the perspective of what it's being used for. It's not ideal for purpose. I mean you've got admin people sitting there within spaces that are clinically set up and yes, it's in really **bad shape**. But would **remediation** cost more than an entire new building? I don't know. And have we got a good enough … have we got good enough **support** to actually, keep it going? We've kind of let it get to this stage on our own.*

IR6: *[K]nowing that building quite well you know, when you get to the stage of delisting, and this is where you have to be **practical**. You've got to balance not just the **ongoing cost** of maintaining the building, but the **realities**, its **functionalit**y and the **feasibility** of maintaining that. At the moment the use of that space is used for things like the infusion centre, dermatology, sort of a lot of amatory sort of base services. And admittedly that isn't working at its best. And the reason I know that is cause I'm constantly getting quotes and requests for refurb and redesign … **Complaints** that you know, we've got to get it painted again. The*

mould has gone through. Some of the concrete as you work walk through, you can see the concrete cancer, I think is the term, that's eaten into it. I know engineering services are constantly ***maintaining*** *that building and it is really quite* ***expensive****. But take away the cost again, back to functionality. And this is where you've got to balance over time the breakeven point of this being satisfactory for clinical use. And you couldn't* ***justify*** *it.*

In conclusion, study respondents identified several financial implications associated with the presence, preservation, and storage of organisational cultural heritage. Key concerns focussed on the costs associated with the ongoing preservation of old buildings, justifying the expense of storage and preservation of movable heritage which may be better managed by alternative state institutions, the need to identify use value within a clinical health setting and the practicalities of storage when space is a finite resource.

Operational Challenges

The second sub-category to emerge from the data that was perceived as a Management Complexities was that of Operational Challenges. Operational Challenges is a sub-theme that encapsulates the numerous complexities surrounding the management of organisational cultural heritage, the operational challenges it represents and the impact it has on the primary goals of the organisation. Child nodes included erases stories, devalues heritage, fit for purpose, neglect alters engagement, loss of character, constant compromise, demolition by neglect, and healthcare first as examples. RPA experiences several operational challenges regarding the presence of both built and movable organisational cultural heritage. Issues include the suitable and unsuitable nature of heritage infrastructure, space shortages, and positive and negative public and organisational member perceptions surrounding the presence and use of heritage.

Several respondents held pragmatic views regarding the tension between supporting hospital primary purpose and the presence of heritage. Respondents highlighted the issues of retaining organisational memory through the preservation of heritage and the impact on hospital progression and innovation. RPA Hospital is not a dedicated heritage management facility therefore management face challenging decision surrounding the retention and disposal of material heritage. It was noted by respondents that the organisation is at risk of preserving too much material heritage which impedes progress and change. While Interview Respondent 13 has demonstrated a supportive attitude towards the preservation and protection of hospital heritage, they were pragmatic regarding how it is used and managed. Space is a premium commodity within a hospital

environment and the presence of inflexible heritage spaces or movable heritage further increases that pressure.

> **IR1:** *[T]rying to keep everything, it does mean we can never **move on**, but it's finding that **compromise** between enough examples of that piece of architecture, of that piece of equipment, of those physical things, that we've got that **retained memory**.*

> **IR6:** *You know, while it's an important way to keep a component of our history, I have to be **pragmatic** as well. And the reality is we can't **save** everything otherwise we'd still be, you know as we were 135 years ago. So, I acknowledge there are certain areas that we may not be able to do much with or we just have to **acknowledge** we're gonna move forward without those.*

> **IR13:** *You know, ideally, wouldn't it be **amazing** to corral this space and put all of the stuff that was in period actually back into it? But again, I don't know. I've never seen it done well, and also you don't want a hospital to be a **museum**. It's not a museum. I think patients don't have enough **space** already. And you know, it would be a hard thing **maintaining** all of it.*

Built heritage similarly poses the same issues as movable heritage but can ultimately be more damaging to the operation of the organisation when a building is kept based solely on notions of architectural non-use values.

> **FG1 R2:** *The Page Chest building, you could have said that was some kind of **example** of a classic building, and it certainly was, but it needed to go the way it did [demolished 2014] for **progress**, to become a modern building. We **need** Lifehouse [building] more than we need that building.*

Built heritage spaces can also negatively impact hospital functionality. Heritage spaces are often inflexible spaces as they cannot be easily readapted for clinical use. Walls consist of thick masonry, ventilation can be limited, and services are often concealed, unknown or challenging to access. Interview Respondent 5 demonstrated a conflicted view in they were frustrated with the front entrance of the Hospital, suggesting it no longer meets the needs of a modern medical facility which requires wide sliding glass doors that ingress to open spaces. Paradoxically they feared their interview comments might contribute to the loss of that heritage which they placed high value on.

They suggested they would be 'devastated' should something negative occur as a result of their opinion. These comments highlight the deep connections held by some respondents to aspects of hospital material heritage. Interview Respondent 5 had commenced work experience at the Hospital as a young adult and at the time of the interview, had been employed for 26 years. This long association has led to the construction of complex mixed emotions surrounding the pragmatics and functionality of heritage aged infrastructure, and a desire to retain the past.

> **IR5:** *Sometimes I think that this isn't meeting the **needs** of a **contemporary hospital** in the 21st century. Just in terms of that front doorway, it's like patients walking through or visitors walking very slowly … But like a wider entrance and ideally that front would have closing doors in terms of them on windy days, dust ingress and so on. Breeze ingress. It just **doesn't work**. Whilst I bring up these **issues**, I think essentially this is important though and should be kept. Maybe we need a different main entrance to the Hospital. I mean, I don't think it should be a priority, but I would be **devastated** if indeed something happened because of my suggestion… But if this was all modernised and nice [indicating image of front foyer entrance], big wide frontage and opening, glass sliding doors, now it'd be **terrible**.*

In addition to the cost of managing aging infrastructure, RPA has a space shortage, and concerns surrounding space were repeated by numerous respondents. Many older campus buildings are small and the only way to effectively expand is to extend upwards. Old infrastructure cannot support this model of change, consequently demolition is required in order for the Hospital to expand. Focus Group 1 Respondent 2 suggested that determining what can be preserved and demolished should be based on architectural interest in addition to building footprint. While acknowledging that Gloucester House contains many organisational memories, these weren't cited as being significant or valuable therefore suggesting the benefits of demolition and redevelopment outweigh those of preservation and adaptation for continued reuse.

> **FG1 R2:** *Even though it [Gloucester House] was built in 1936, it's not particularly **aesthetically** pleasing. I mean it's got a lot of **memories** attached to it but it's not particular aesthetically pleasing you know, whereas this building is [indicating KGV]. It's got a bit more to it, I think. And ultimately, you've got to make the kind of **decisions** to use the land that you've got, otherwise the options for **redeveloping** the Hospital you know will be **limited** but yeah, it's a tricky kind of proposition developing an old site. It's like my view of the pathology*

*building, to me that has more **architectural interest** than Gloucester House, but you now, it may still be in the way.*

Other respondents were more inclined to support adaptive reuse but acknowledged the complexities surrounding this in that spaces within the building are not suited to many purposes. Interview Respondent 6 evaluated the use-value of Gloucester House determining that a pragmatic solution would ultimately see it redeveloped or at least integrated into a new building. Interview Respondent 1 noted the challenges faced by hospital management when resources are limited. Healthcare and hospitals are an ever-expanding sector that require constant reinvention and progression. The need to make challenging decisions surrounding the management of heritage is an additional variable and complexity that RPA engages with across the organisation as a part of core operational business.

IR6: *Gloucester House is a fairly **big footprint**. I couldn't justify putting administration services through there. We wouldn't even have enough to fill it. And this is where I think we have to then become practical ... It's probably gone beyond its potential use-by date, both in **cost and functionality**. And then it wouldn't be unreasonable to say, well, if that's the case, we should look at what we will do with that land site. The footprint there again an **integrated model** would be lovely cause you don't want to lose the history. But I do think that's one building. I know that that is extensively difficult to maintain.*

IR1: *[I]t does take up a considerable **footprint** and doesn't deliver, so there is always that challenging decision between what are we **sacrificing** in keeping this and what are we sacrificing in getting rid of it and I don't see any simple answer to that. I don't think there is any easy **formulae**... And it comes down to like so many things in life, there is **infinite demand** and **finite resources** within which to deliver a kind of thing, and it means sometimes having to make some very challenging decisions.*

The allocation of space to the RPA Museum proved a contentious issue with some respondents. Interview Respondent 5 noted that some staff feel the museum is a poor use of space, and an unnecessary component of the organisation and intrusion on the daily operations of the Hospital. Staff were noted to 'roll their eyes' which is suggestive of contempt and a dismissal of and challenge to the value that the museum and material heritage may represent.

IR5: *I know there are some staff members who've mentioned it to me and kind of roll their eyes, go what a* ***waste of space****. But none of them have been, and I bet if they came they would change their view. But that's your issue isn't it, getting people to come in the first place. People come to work to, well, work.*

Moderator 5*: So those staff members who* ***rolled their eyes*** *and said it's a waste of space. They see space being merely a functional hospital tool?*

IR5: *Uh ha, that's all a building should be. Yeah. Every space should be* ***utilised*** *as best as can be done with a very* ***specific hospital function****. In our case, working at a hospital, this is a* ***waste of space*** *I've heard. I don't agree.*

As the SLHD population grows, so too does the number of hospital attendances. Focus Group 2 Respondent 4 noted that decisions surrounding demolition and redevelopment of built heritage are complicated but ultimately need to serve the primary purpose of the Hospital and that of the local community. They interpreted and articulated such decisions as life-or-death ones, that on one hand require thoughtful consideration, but on the other is uncomplicated and easily decided upon. Heritage is not more valuable than human lives, and when heritage puts the health of the community and lives at risk then it should be removed.

FG2 R4: *I mean just things like that with* ***complicated*** *decision making are tough, cause obviously if it's between – well if you don't put another building in this block and it's the only place we've got and were gonna have an extra thousand person* ***die*** *in our district every year. That's a big deal, it* ***weighs*** *against it. But at the same time, it can't just be something that's whacked out. When people are going to die if we don't knock this down, so* ***bad luck****.*

As the district grows and the services expand, strains on resources also include strain on organisational members. RPA has a limited number of inpatient beds. Once the Hospital is at capacity there is increased pressure on hospital treatment and discharge rates which then impacts staff member workloads and by extension member health and wellbeing. Organisational culture is significantly guided and impacted by member interpretations of hospital workload.

IR4: *But then at the same time with the increase in the* ***population*** *and the* ***strain*** *on services, we probably do need to do that (demolish buildings). Otherwise, it just leads to us not having enough beds and we're* ***overworked****.*

This is furthered supported by Interview Respondent 13 in that the management of heritage and the management of staff and patients are intricately linked. When one is effectively managed meaning respected and cared for, so too will the other be. The downstream result being increased mental health and well-being for staff, increased quality of care for patients and as a result faster discharge rates and increased operational efficiencies.

> **IR13:** *[I]f we do the right thing with our buildings because you know, you can't have a* ***crumbling*** *building and think that the* ***care*** *inside is going to be any better than the building on the outside. I think we have to commit to looking after the buildings on the inside to look after the* ***patients*** *and* ***staff*** *on the inside because they are one and the same. They have to go together. You know, you don't invite somebody to your house, and it's an absolute shit fight and think that they're going to get a clean cup of tea. I think there's a lot of research around* ***environmental****. I think people need to heal in the places that you know is* ***relaxing****, is fine for them. And it actually gets people out quicker and all of those things, I think getting this right is important.*

Other respondents noted that old infrastructure is often not fit for purpose and that pragmatic decisions regarding functionality should be the key consideration when managing the built environment at RPA. Focus Group 1 Respondent 2 noted that the emergency department, situated within the 1901-built Albert Block is no longer an effective working space and again reiterates that the Hospital is at capacity regarding patient presentations and admissions. They noted that a 'value judgment' must be made weighing the health of the local community against the ongoing presence and maintenance of hospital heritage. Other respondent discussions further supported these ideas recognising there is a tension between the retention of heritage and the delivery of effective health care. Again, the adaptive reuse of heritage spaces is considered one answer however respondents were very clear in noting that the Hospital's primary purpose and the impost the presence of heritage is having on those services.

> **FG1 R2:** *ultimately you know a hospital has to be* ***functional*** *otherwise, you know I'm acutely aware the emergency department is no longer* ***fit for purpose*** *and the whole hospital is bulging at the seams, so they've got to build, and there is only a certain amount of* ***footprint*** *so I guess ultimately you have to make a* ***value judgement****.*

PFG R1: *[B]ecause I guess the tension is, you know, do things that are not* ***fit for purpose*** *impact on the way we* ***deliver care*** *to patients and families, and that's ultimately what we are there for. I think that's a huge tension, I don't know what the answer is. You know something though, it is a good question because, I guess the question would be can you find a* ***new purpose*** *for these buildings because they are not fit for what they used to be fit for.*

PFG R2: *No (agreement).*

PFG R1: *Cause if you look at old Florence Nightingale wards, although I like them, you know they are* ***not fit for purpose*** *now.*

PFG R4: *Yeah.*

PFG R1: *So, I guess the organisations got to manage the tension between* ***retaining history****, while making best use of the space that it actually has.*

A key concept that emerged surrounding the ongoing degradation of built heritage was that of the image it presented to staff, patients, and visitors. It was suggested that ageing infrastructure may be viewed as a reflection of the level of care provided by the Hospital. Patient and visitor perceptions surrounding healthcare are often guided by notions of modernity, innovation, and technology. Degraded infrastructure is suggestive of resourcing issues which may be perceived as impacting on best practice and the delivery of care. Interview Respondent 1 proposed that first impressions created by some built heritage and heritage spaces may misrepresent the organisation, which is in direct opposition to those notions that suggest heritage conveys prestige and confidence. Poorly maintained and presented heritage spaces may erode confidence in the Hospital's services and damage its prestige conveying a message that the Hospital is dated and not in line with healthcare best practice.

IR1: *We might have the most beautiful shiny wards inside but if people's* ***first impression****, when they walk up to a building is that it's* ***cruddy****, and it's* ***dirty*** *and it's* ***poorly maintained****. I think recovering from first impressions is always incredibly difficult. And I think that we are so far behind that you could still walk into that* ***beautiful ward****, and that* ***cruddy impression*** *is not necessarily going to be removed from your mind.*

PFG R2: *I think things have to be kept up, have to be* ***repaired*** *and* ***replaced*** *and* ***refurbished****, I mean if you go to a place and it looks like 1940, am I gonna get* ***1940 treatment*** *here? That's how people feel…*

> **IR1:** *But I think also, when the sandstone on the main entrance looks **nice**, and looks **clean**, and hasn't got the pigeon poo all down the front and all the rest of it. It does go back to that **reinforcement** of people's **beliefs** that if it looks good, then good stuff must be happening in there as well. So, if we are going to keep our heritage buildings and spaces, then although we aren't going to make them look like shiny glass buildings, we still do need to make sure we make them look like they are **functional and clean** and that **good care** is possible, can be delivered inside them.*

One respondent further noted that containing a rich history can present a false image of financial stability. There is an external perception that as RPA Hospital has successfully endured, has a strong reputation, and is situated within the City of Sydney, it is well funded. Focus Group 2 Respondent 4 suggested the age and nature of the campuses built heritage might support a false image indicative of wealth and abundant resources. This in turn instils confidence in the organisation and the services it provides which suggests that the Hospital heritage should be actively supported and emphasised as a key feature.

> **FG2 R4:** *Built structures add **intrinsic value** to this anyway. I was at a function last week and the four GMs of the SLHD were all there and T [Chief Executive] was on one of the panels and she said, 'Even though we have old stone buildings, we're not the **wealthy** one.' But there's an **impression** still that it's the premier place and because it has that, it will go towards **patient confidence**, but should also go towards government **funding decisions**. This is the place that has the longest heritage and is the most **important**.*

Although acknowledged as challenging, the successful integration of heritage movable artifacts and built spaces into modern redevelopments was widely considered a solution to the ongoing issues surrounding the management of heritage spaces. Heritage buildings and spaces not fit for purpose could be demolished and refurbished with some aspects of the existing heritage reintegrated into new architecture. This was considered possible in non-clinical spaces where sterile environments and innovative technologies are not required. Further, respondents noted that integrating heritage features into new construction would add warmth and character ensuring the 'sterile' and bland architectural design often associated with healthcare design is avoided or minimised.

> **IR13:** *So, if there was a way to keep it there whilst getting our **needs met** without it being too much of a drama, that would obviously be best case. If you could keep the front facade and it*

*is an interesting way to **incorporate** it, great. If all you can take is the top bit and put it somewhere else, great. But I'm fairly anti removing stuff to put something modern down when with a bit of **time** and a bit more **finance**, we could incorporate it somehow.*

FG2R9: *[M]y opinion is I think you can do a bit of **both**. Where you, if you **preserve** part of it because we are in a demographic here where it's growing and we're already running out of space. I think we need to **expand** and we can't, to do that you have to take out buildings but I think you were to, I don't know the logistics of it all, but if you were to keep **part of it**, like I don't know if you could fix part of it or put things through the building that you keep, then it's not so **sterile** in common places where you kept parts of the building.*

IR1: *That's sometimes the **challenge** then. How do we **incorporate** that history in a modern health care centre?*

Respondents highlighted the successful integration of RPA heritage into redevelopments of the past citing the 2005 retention of the Nurses' Home Courtyard and the redevelopment of Liverpool Hospital. By looking to retain the 'highest value' areas the organisation had found a successful balance between creating a functional space and respecting and preserving some aspects of the Hospital's heritage. Areas that were once viewed as 'derelict' and 'ugly' were repurposed into spaces that staff actively engage with.

IR1: *I think this is a **really difficult** one, and particularly with architecture, looking for example, at this picture of the Nurses' Home [picture of courtyard fountain built in 1890]. So, there was a point in time, before they actually tore the old Nurses' Home down, that I was sitting in an office looking on the courtyard before it was **renovated**, and it was pretty **ugly**. We had gone from a period in time when obviously it was a central courtyard and a hub of this very active Nurses' Home when most nurses lived on site, to when it was very **derelict**. To then a point where we did need to tear a lot of that building down to create **functional** clinical spaces, particularly with the new maternity centre. But we looked to **retain** almost the **highest value** parts of that. We've retained the **facade**, retained the courtyard, making that now part of this new central area thing, so I think it's sometimes that **compromise** between the **functionality** of a building, and building or developing a new space that also **integrates** bits of the old. It can be done and that **proves** it.*

> **IR6:** *This happened actually at Liverpool, which is another hospital. And the reason I know this, we were occupants at the time, part of their building and they were going to knock that down. But the actual building we were in was over a* ***hundred years old****. And what they did was they* ***factored*** *in the entrance, so they kept the* ***old entrance*** *and the* ***facade*** *of that into the* ***new building.***

A further dimension associated with the continued modernisation through demolition and redevelopment that emerged from the findings was that redevelopment can devalue and weaken the significance of heritage spaces across the Hospital. The loss of heritage across the campus has been identified as occurring through incremental stages and has often happened undetected. This erosion of material heritage alters the nature of the surrounding heritage which the changes meaning and significance to those that engage with it. Respondents perceived these changes as devaluing heritage which can ultimately change the organisational identity and culture.

Further, Interview Respondent 13 noted specifically that both community and staff would ultimately 'judge' the organisation for its treatment of heritage. This interpretation of heritage management connects back to how organisational members perceive hospital management teams to value the organisational past. A failure to respect hospital material heritage is interpreted as a failure to respect the organisational history including its staff members which is damaging to organisational culture. Negative changes in culture lead to disengaged staff which lowers best practice across the Hospital.

> **IR13:** *Cause I think, you know, we can* ***erode*** *all of the buildings around the campus then we have no history. You know, Page Chest [building] came down. All of these old buildings are coming down and we're ending up with very, very* ***modern*** *builds. But is this, the front of the main hospital, the* ***only thing*** *you want left? And then* ***how long*** *will that last? So, I think we can choose to do things like* ***sell*** *Queen Mary [Nurses' Home] on the proviso that it stays looking the same and earn money to build Marie Bashir and then be knocking down some of our other stuff. Or we can be actually* ***sympathetic*** *to what's going on. I think you've got to be* ***consistent*** *no matter what frame we're applying. So that's sort of my feeling, is you either* ***value*** *this stuff and you maintain it and you look after it, and you choose how these things move forward or you* ***let it go****. But be prepared that, you know, I think not only the* ***community*** *will* ***judge*** *you. I think* ***staff*** *too.*

IR7: *… I kind of feel like we erode the edges. So, if we take away this building or statue or whatever bits of heritage, we start to* ***erode*** *the* ***edges*** *of these places. If we start to* ***silently*** *just remove that and silently remove that, it's not giving the* ***community*** *the opportunity to actually fight for what's there because they don't know one and two. We're doing it so slowly that you will never even potentially realise, but those of us who are here a lot just go, well, that was a* ***shame****.*

IR4: *And then the more modernisation of the Hospital sort of* ***devalues*** *the older parts of the Hospital. And then it's like, well, why hold onto the older parts if all the other parts have been modernised. Let's just modernise everything.*
Moderator: *If we knocked out all the RPA old spaces and had a brand-new RPA, is it still RPA?*
IR4: *Not to me. Yeah. No, not to me.*
Moderator: *What do you mean, in what way?*
IR4: *It'll just be different, no connection to the, you know, where we've come from which has made us this amazing hospital, you know, who we are today. We need to see it and be reminded of it.*

These notions concerning neglect and the resulting disengagement of staff, patients and visitors were reiterated by respondents on several occasions suggesting it a common theme and concern amongst some staff members at the Hospital. By not maintaining heritage, Focus Group 2 Respondent 1 suggests patients, staff and visitors risk viewing it not as valued heritage, but as degraded, unvalued infrastructure. The connection to the past becomes splintered, forgotten and 'erased'. Further some respondents viewed heritage loss as an irretrievable and irrecoverable action. The removal of artifacts and the redesign and modernisation of heritage spaces not only alters the character and identity of the organisation but it also changes the narrative and creates a new story, often to the detriment of the old one. Interview Respondents 2 illustrated extremely strong views surrounding the museum and hospital material heritage. They used the word 'die' in connection to heritage loss, which suggests the end of organisational stories and narratives which in their eyes effectively deletes them from the Hospital's history.

FG2 R1: *[G]oing back to some of these older buildings as well as when they're not* ***maintained*** *enough, they actually become old buildings that nobody's* ***interested*** *in due to* ***neglect****. So, I think that we need to be* ***maintaining*** *them and, on the inside, we can still*

*make them **functional** for the use that we need. And when we make new buildings, brand new, you know, 10-storey buildings, we **add elements** back in so that we can remember what was there. You have to keep that **story** going somehow otherwise I'll just be lost and forgotten.*

IR2: *I think it'd be a **crime** to close the museum, if that's on the cards. I've got a daughter who wants to be a curator, remember. Once you shut things down or don't make them **accessible**, they **die**. And once they die, they, well, they don't come back.*

IR10: *I think it [demolition and object removal] just **takes away** all that cultural heritage and all that **history**. It would kind of just **erase** those **stories** a little bit and then [it] starts a fresh new set of **stories** for our time. And I think then it **loses** a bit of that **character**.*

When discussing long-term staff members, respondents noted that institutional behaviours, and organisational memory increased the complexity of heritage management. Institutional knowledge encodes memory, and therefore sets behaviours and practices. Respondents viewed this as a barrier to innovation and progression. Healthcare is a field that utilises past knowledge and practices to further current knowledge and practices but in doing so should never operate or rely on past behaviours alone. Interview Respondent 3 further noted that some current practices are not based on evidence-based best practice which they suggested is a result of embedded historical behaviours as a result of strong ongoing linkages to past practice. They further suggest that the Hospital's reputation in some instances is undeserved as a result of historical behaviours.

Moderator7: *So, you're saying long-term staff can pose **negative** issues too?*
IR7: *Definitely. Yep. But not even just the staff, more the way the place is managed or the way that the organisation is set up or **hierarchy** of things. The org chart, any of that. **Historical practices** get in the way of **innovation or progression**. We need to modernise, and they only know one way or will only do one way. This is the way we've always done it.*

IR3: *But yeah, it's interesting to me that idea cause it, yeah, sort of goes against the whole evidence-based thing of you should be doing what's new and current. And it doesn't matter what people did in the past … In fact, there are practices that we have as a direct result of having been around for so long that are **not best practice** but because we've got people who are really **entrenched** in how they've always done things, that's actually a drag on **progress**.*

So again, this doesn't really make sense that an older place would be better … If you think it's a bad thing that well sort of jumping on the bandwagon of an old hospital is necessarily a better, more prestigious hospital. I think being aware that doing things for ***historical reasons*** *can actually get in the way of doing* ***evidence-based*** *practice is important.*

Operation challenges not only exist in member inability to change but also in a refusal to change resulting in what they perceived as challenging 'ingrained' behaviour and practices. Interview Respondent 9 noted this as a discussion point amongst staff that requires careful navigation, and a barrier to effective operational outcomes.

IR9: *Yes. Yeah. And I think the people that have been here for a* ***long time****, are very like* ***ingrained*** *in what they do and set in their way and very like, I wouldn't say* ***backwards****, but they are still working within that kind of way that they've always worked, and everyone just knows that that's how they are. And we kind of* ***talk*** *about that in general about them.*
Moderator 9: *A lot of people have used that terminology* ***rusted on*** *[laughter], they have ways of working and thinking that can be detrimental to the organisation?*
IR9: *I think they can be. I have personally seen it. I know that they are, you've just got to know certain ways to* ***approach*** *or to talk to certain people to get your perspective across.*

The final theme that emerged surrounding the management of hospital cultural heritage involved respondent perceptions regarding heritage management responsibilities. Respondents noted that intentional neglect leading to demolition is a common theme in the local community. The result of neglect in their view made decisions considered challenging, easier for government organisations, and suggested such behaviour exists at RPA. Further, that an elevated level of responsibility exists surrounding the preservation of heritage still in use.

IR3: *Oh, [demolition] that's outrageous. Captain Bligh's daughter lived in a little cottage behind where my parents live up in Newtown, her actual cottage was there until last year. And the people who owned it had put in a DA to* ***demolish*** *it and build townhouses. And the council was like, 'Oh, I don't know, it's Mary Bligh's actual cottage.' And so, they just let it* ***fall down****. Yeah. They let it fall down until it became unsafe to live in. And then the council said, 'Oh yeah, it's* ***unsafe*** *to live in now, you can get rid of it.' So, I don't think that makes, I mean it obviously makes someone's* ***decision easier****. I just think that's so wrong. So,* ***wrong****.*

Moderator 3: *So, as an organisation, particularly that we work in government, do we have a responsibility?*

IR3: *Yes. Yes, yes. And you know that conservators are **expensive**, too bad, you shouldn't have let it get run down, **maintenance**, you know? They send you out a thing in this council area saying keep your house maintained cause it costs a lot more to get it repaired if you let it get run down. It's like yeah, listen to yourself. Don't let our historical stuff get **run down**, yeah. Do exactly what you're telling your householders in your council to do.*

IR5: *The fact that it's a bit **run down** is not the building's fault. It's possibly **demolition** by **neglect** almost. We have a **responsibility** or plainly the Health Department, Ministry of Health, has a responsibility to maintain these facilities, particularly if they're still being **utilised**. The fact that it's not fit for purpose or whatever, it's not the building's fault.*

IR7: *It's still a **living, breathing, functional space** okay. We have a **responsibility** to look after it. Absolutely. We do. And it has been, I mean, it still is **beautiful**.*

Responsibilities surrounding the protection of heritage are additionally complex when buildings, spaces or objects are donated or funded by members of the Hospital or the wider community. Interview Respondent 5 stated the organisation has a responsibility to protect that which has been funded or gifted by donors including construction of buildings, furnishings within buildings or donated medical equipment. RPA partially funded the construction of several buildings via subscriptions including the RPA chapel which sold bricks to members of the public and staff. The stained glass windows located throughout the chapel were also donated and various other components of the furniture and fittings were funded by groups and charitable organisations. The respondent noted that the Hospital has a responsibility to respect those donations and honour them into the future.

IR5: *I actually think it's important umm I forget who made the **donations,** public subscription or whatever, but it's a much newer building about 1950s [RPA Chapel] or something. As a result, we have a **responsibility** to protect and maintain something like this. Other people paid for it.*

Moderator 5: *But if the chapel's not really being utilised, and I don't really think it is being utilised to be honest, why keep it?*

> **IR5:** *I think it's one of those things where if someone's done something to get them onto that panel for having donated so much money. To me there's a bit of* ***respect*** *for the people that paid for it to be built, be it one individual, the Kerry Packer chapel ...? Laughable. But even if it's just public subscription, all these people putting in two pound or whatever and raising the money for it. I think those things rather than the ones that are entirely paid for by Health, the Health Department, there's a certain* ***respect*** *for the people that gave the money. Be they many, many individuals or one rich individual, we are* ***responsible*** *for maintaining it.*

In conclusion, study respondents identified several operational challenges surrounding the presence of built and movable cultural heritage at RPA. Two central and core themes however emerged. The first evolved around the unsuitable nature of hospital heritage infrastructure, and the impact limited and unsuited heritage spaces have on staff member workloads, and by extension health and well-being. The challenges surrounding hospital space was noted as a limited and valuable resource that respondents stated must be selectively managed to ensure hospital best practice is achieved, and successful patient outcomes are realised. The pressure of space was also experienced by staff members who felt the pressure of limited resources impacting their working environment, which had a flow on effect of impacting staff member behaviours, and culture. Respondents specifically noted that heritage facilities such as the RPA Museum utilise space that could be repurposed as office space, or with some investment be adapted to suit other non-clinical services. Other themes raised include the unsuitable nature of heritage infrastructure with respondents noting concerns surrounding hospital functionality and the ability to maintain best practice across the services.

The second core theme was associated with the irrevocable loss of heritage though mismanagement or neglect. Respondents suggested the operational challenges faced by resourcing issues saw heritage become progressively degraded and eroded. This was viewed as damaging to the Hospital image and identity, staff culture, and to consumer and staff confidence. Paradoxically, the presence of heritage was viewed as a component of the Hospital that supports and increases patient confidence as the presence of heritage reflects longevity and permanence.

Conclusion

As discussed in Chapter 4, several tenets of grounded theory were incorporated into the methodological process and applied during the data collection and analysis phase of this thesis. By constantly comparing and analysing emergent codes and constructs in NVivo 12, sub-categories and

core categories were developed from which major five themes emerged. These themes provide insight into:

(1) What is perceived as heritage at RPA,
(2) How heritage has been collected,
(3) The ways in which it is actively and passively engaged with and used,
(4) The benefits and challenges it offers to both the organisation and to individual members,
(5) The implications and impacts on hospital operations now and into the future.

These themes can then be used to explore the main thesis question: ***What is the meaning and value of organisational cultural heritage to Royal Prince Alfred Hospital?***

It was found that RPA organisational members offered complex interpretations of heritage meaning and value with understandings proving varied and sometimes with contentious meanings. The easily identifiable material objects were widely discussed, but so too were non-material dimensions to heritage such as the stories and memories associated with the Hospital illustrating that perceptions of heritage are fluid and wide-ranging. The presence of heritage was seen to underpin and strengthen the Hospital's reputation and prestige, providing credibility and a sense of gravitas. There was however some argument as to whether this reputation is evidenced based but is instead a manufactured image perpetuated through the continued use of material heritage. Some study respondents failed to recognise the value of heritage beyond superficial emotional responses interpreting heritage largely for its artistic value. Further, that the unsuited nature of built heritage unnecessarily and negatively impacts hospital resources and operations. In contrast, there was also significant data to suggest heritage directly and indirectly supports a positive workplace experience and environment. There was also discussion surrounding the selective and exclusive nature of hospital heritage as overwhelmingly representing those staff members in positions of power. The hierarchical nature of hospitals has led to the development and collection of movable heritage representative of educated elite white males to the exclusion of other members of the Hospital staff. This is suggested as further perpetuating male patriarchy and not an accurate representation of RPA in 2023. Paradoxically, others viewed such heritage as inspirational and motivational, attracting them to employment at the Hospital and stimulating pride and pleasure in their role within the organisation.

These themes will be further analysed in the following chapter providing an overarching discussion and general conclusion. Concepts explored in the literature review will be integrated with the

emergent themes developed in this chapter in relation to the research question, aims and objectives.

Chapter Six: Discussion

Introduction

The purpose of this chapter is to address the main research question - ***What is the meaning and value of organisational cultural heritage to Royal Prince Alfred Hospital –*** and to draw conclusions from the findings. It does this by synthesising the historical backdrop and organisational background information developed in Chapter 2, the literature review and established concepts explored in Chapter 3, and the major themes that emerged from Chapters 4 and 5. The key themes are integrated into an overarching discussion exploring the value of heritage to RPA Hospital, and the implications of the presence of heritage as perceived by organisational members.

There is both a tension and balance that exists across the organisation between heritage as a representation of the past, and heritage as a tool used to help frame and interpret the future. RPA is, consequently, a site of struggle. That struggle exists both as a resistance and a desire to change and to stay the same. It is an organisation deeply connected to its historical journey but also one that strives to be innovative and new. It strives to change and adapt whilst also actively sustaining links to the past. Further, it uses its past to underpin that change and adaptation. RPA was founded on principles of modernism and innovation and has espoused and supported similar values and beliefs since foundation and across time. It relies on heritage and the past as a significant articulation and reinforcement mechanism used to embed these same values, beliefs, and assumptions. RPA actively uses, and as will be argued, relies upon heritage to connect its past with its projected future. While findings from this study demonstrate that there are significant advantages to using organisational heritage as a management device, there is also contention and conflict surrounding how it is used. The following sections will analyse and contextualise these concepts.

Discussion

Inclusion, Exclusion, Representation and Organisational Heritage

Within wider sociological settings, the presence of heritage is today interpreted and viewed as having complex and diverse social meanings based on individual and wider social and cultural identities, and enculturation processes. The early heritage of RPA was developed as a result of actions centred around values derived from the colonial settlement of Australia, and from having emerged from the British empire. RPA was constructed as a monumental celebration to the British

Royal Family. These actions stem from socio-cultural values reflective of the 19th and 20th centuries, and embody the positional power held by educated wealthy men largely of European descent. The immense amount and types of material heritage located across the RPA campus is evidence of this. Foundational figures associated with the construction of the Hospital and figures deemed instrumental to the development of departments and medical streams are celebrated throughout RPA's facilities through an array of material heritage types. How this heritage has been interpreted and responded to during this study has demonstrated that heritage meaning and value, framed within an organisational setting, offers complex and conflicting meaning and value to organisational members.

While there is a clear divergence in meaning and interpretation of hospital heritage, heritage was identified by respondents as possessing all those socio-cultural values readily accepted by the heritage sector including associative, aesthetic, historic, scientific, symbolic, and social (pages 158, 161, 165, 186, 195). However, like culture, which Harrison (2000, p. 426), argues cannot be fixed but 'instead continually changes as it is a contingent, contradictory, ambiguous, multivalent phenomenon', so too are interpretations of RPA heritage. When culture provides a means for the transmission of meaning across society, so too does material heritage at RPA. Findings suggest that RPA heritage acts as a medium for the transmission of organisational cultural values across time and space. Further, RPA heritage has undergone a continuous process of interpretation, which Graham (2002) argues, is selected or discarded as the social environment evolves. Meaning and interpretation of heritage at RPA has been shown by this study to shift in parallel to changing social and organisational values.

The evidence from this study suggests there is an ongoing attempt to fix, lock or make permanent organisational values at RPA through the use of material heritage and heritage spaces. Accepting that modern culture is viewed as fluid and changeable (Whetten 2006), which parallels the nature of modern healthcare systems, accepted as complex, adaptive microcosms of society, such actions create an environment burdened with culture and identity conflict. RPA heritage has experienced significant reinterpretation and is viewed by some as stagnant and non-inclusive. The AHD defined by Smith (2006) is identified and penetrated by some staff members who recognised deeper meaning and who held conflicting sets of values regarding hospital heritage (pages 160-161). The first layers of culture identified by Schein (1991) are a source of tension as conflict emerges between the fixed nature of RPA organisational values, or by the attempts to fix them, and the constantly evolving and reconstructed nature of the socio-cultural value of heritage.

Key findings surrounding the recognition and interpretation of material heritage at RPA indicate that organisational staff members experience strong responses to RPA heritage which generate feelings that traverse a wide emotional spectrum ranging from disgust and frustration to awe and inspiration. These emotions are direct responses to feelings of exclusion and inclusion (pages 173, 182, 190). This information offers further insight into the impact of heritage when viewed as containing conflicting values. It also offers insight into the strategic management of organisational values through representations of heritage, discussed later in the chapter.

Central to the conflicted views surrounding hospital heritage was the selective nature of heritage material across the Hospital, and the total exclusion of First Nations People, and the limited representation of both woman and their wider organisational roles within this heritage. This was interpreted by hospital staff members as underpinning and propagating the hierarchical nature of hospitals which in some respondent views further support outdated beliefs, values and assumptions that exist within RPA's culture and identity. Heritage was perceived as having been developed and installed as monumental celebrations to a very limited and specific selection of the Hospital employment base. Such use of material heritage propagates narratives that Smith (2006, p. 299) suggests are limited to those 'elite class experiences' that actively exclude other voices and experiences from across the organisation. Doctors were described as 'king' and resentment and frustration surrounding their elite status was evident as a result. Heritage was viewed as having been collected and celebrated by those staff members in positions of power - educated wealthy white men - and whose collection rationale was framed around and intentionally limited to their organisational specialty or social status. This created feelings of exclusion and isolation amongst some female staff members, and those staff members who were not doctors. Collections were specifically interpreted by those members experiencing feelings of exclusion as having been coordinated and developed by leadership staff perceived as meaningful to them only and not meaningful to other individuals across the Hospital, or to the wider organisational story.

While this evidence supports those arguments that suggest collection motivations 'pertain to self' as well as to 'acts of preservation', importantly, it also frames hospital heritage as organisational artifacts and cultural material that can only be derived from material associated with staff members in positions of power. In other words, the socio-cultural value of RPA heritage is perceived as high if associated with people or roles within the Hospital perceived as important and of high value to the organisation or is perceived as low if associated with staff members and roles that fail to meet this

criteria. This appears to have occurred both by management design and as an outcome of 19th and 20th century hierarchical social divisions. The limited representation of female staff members throughout the organisation's material heritage has led those respondents to feel undervalued and as unrecognised organisational members. Selective heritage representation both diminished the status of their role within the Hospital while further elevating and propagating the status of doctors. This has the capacity to further drive what is already viewed as a differentiated and fragmented organisational culture.

Hospitals experience differentiated cultures of medical, administrative, and engineering groups that are further fractured by specialties, service lines, occupational groupings, and hierarchies (Davies et al. 2000). RPA heritage is a core component of the Hospital's culture in that it persists across all three levels of Schein's (1990a) organisational cultural model. It is an easily identifiable and observable artifact, it is integral to the dissemination of organisational values, and it is an intrinsic driver of the organisations basic underlying assumptions. Findings from this research demonstrate that heritage can be viewed as an additional organisational cultural artifact, and socially and culturally divisive factor that can represent alternative espoused values and beliefs. These values and beliefs are entirely dependent upon individual and group interpretations of heritage. RPA heritage can then be seen as influencing the wider organisational culture further supporting those notions that organisational culture and heritage are both products of human enactment and a product of the environment. Heritage as an organisational artifact in this context is an enacted process of social engagement that impacts on the cultural language used by staff that underpins shared assumptions. Consequently, the presence and use of heritage can contribute to cultural differentiation which in turn impacts staff member motivation and workplace performance. It does so through further dividing these already differentiated hospital groups containing diverse views and norms, based on gender and educational background, and the social groupings or subcultures that emerge as a result. This differentiation then supports the development of multiple organisational identities derived from perceptions of heritage. These identities contain conflicting value systems that cannot be reconciled as a unified single identity but instead persist as fractured identities attached to organisational specialties. They are grounded in a larger insecure and fractured identity whose construction is based largely on image and perception, and as will be shown later in the chapter, is argued by some respondents as not evidence based.

While the discussion thus far has focussed on the exclusive and divisive nature of hospital organisational heritage, heritage at RPA was also found to generate a wealth of themes consistent

with concepts of inclusion and unity. Findings from this research demonstrate that through heritage, RPA values are created, maintained, reinforced, and communicated to hospital staff members. Although hospitals are identified as consisting of a myriad of subcultures, often in conflict, the presence and maintenance of heritage spaces, statues and portraits across RPA generated largely positive emotional responses that in many instances created a sense of unity and bondedness amongst staff. Through including heritage in modern departmental wall graphic historic timelines, communication strategic documents like the Year In Review, and other symbolic celebratory milestones, many staff felt included and a part the history of RPA. They felt recognised as important to the organisation and valued alongside senior medical staff. This led to a small but significant shift surrounding the negative perception of hierarchical division and those associated power relations. By extension they identified as feeling better connected to and as a part of the organisational story. When staff described coming together in discussion around heritage walls and heritage material, feelings of pride were generated, and as a response departmental bonds were strengthened, and cultural and organisational unity supported. Such patterns of influence were common findings within the data. They foster intergenerational connection and strengthen the organisational collective memory.

Despite the division caused by the limited heritage representation of staff members and a perpetuation of the AHD, the presence and use of RPA heritage has also been shown to support cultural convergence and the development of common organisational identities. Staff members were identified as using localised and departmentally specific heritage as social and professional identity referents, as well as wider non-specific organisational built and movable heritage as organisational identity referents (page 178-179). Encounters with heritage often provided a reminder of the organisational journey and of the legacy built by the Hospital (page 181). Through recurring acts of remembering the past, staff members experienced reverence and pride and were inspired and motivated to strive towards and seek best practice (page 185). This facilitates departmental and by extension organisational action and effectiveness. Further, through passive engagement, bonds and connections were constructed in response to heritage that they perceived as prestigious, awe inspiring, respected, and esteemed (page 183). These bonds emerged through a rhetoric and a common understanding that they are ‘an RPA man or RPA woman’. They were able to identify as an RPA staff member which in and of itself is suggestive, in their mind, as a pinnacle achievement.

This common understanding is also a central component in the development of a cohesive organisational culture. It is the 'social glue' that generates a 'we feeling' that counters any differentiation that may emerge. Shared values and beliefs can greatly influence organisational member feelings and thoughts (Furnham & Gunter 2015), providing social and cultural benefits that underpin and actuate those superficial espoused cultural statements prevalent across the Hospital. Hospital staff members can as a consequence become more engaged, inspired and committed to their role and to the organisation.

Organisational Heritage, Member Behaviour and Management Control

While findings from this study demonstrate what RPA heritage 'does', findings have also highlighted the ways in which heritage has and is being used. It is evident that selective heritage preservation has been actively pursued and engaged with as a management control mechanism designed to elicit specific responses to heritage, and by extension the organisation (page 159). The ongoing presence and protection of heritage is a strategic action designed to regulate organisational culture at RPA by reinforcing both old and new organisational values.

Further interrogation of the inclusion/exclusion theme finds that heritage has been interpreted by some respondents as more than a product but also as a process (page 159). By this, they do not mean a process of heritage-making in that interpretation and values emerge through acts of engagement and constant revision, but instead as a process of behavioural regulation and manipulation through managerial control. In their view, the process of heritage making has been reserved to and for élite level staff members such as doctors and executive management. Heritage making can only occur through élite level staff as only élite level staff have the knowledge and information required to determine what is and is not of organisational value, and what can or cannot meet appropriate levels of significance required for heritage status. Staff members not in positions of power and authority were in their view not authorised or supported to actively identify and preserve organisational heritage (page 160). On one hand this finding is unsurprising in that authority, power and hierarchy have and continue to dominate hospital organisational structure and management (Jacobs et al. 2013; Rosario et al. 2023). On the other hand, while material heritage and the AHD has to some degree continued to define, legitimise, and control the hospital historic narrative though the presence and use of selective material heritage, heritage itself as a 'process' has been manipulated and controlled.

While the literature argues that heritage is sustained through a continuous process of interpretation (Kirshenblatt-Gimblett 2004), and can be selected or discarded as per the demands of a changing society (Graham 2002), findings from this study suggest that within an hierarchical organisational setting like a hospital, authority and power define what is to be situated within this framing. Therefore, heritage significance and the socio-political characteristics of RPA heritage was from the outset bound within a framework of preconceived values. In other words, hospital material heritage was perceived by respondents as having been pre-framed in the minds of organisation members as only belonging to a specific cultural and social grouping within RPA, and that only that social grouping could identify and select heritage (page 160-161). That social grouping was, as described by Malavisi (2018), 'deemed to have a higher epistemic authority, and hence credibility, than the knowledge of others'. The manipulation and distortion of knowledge regarding who can and cannot make heritage ultimately limited heritage as a process. The outcome of this being that those residing external to that framing were coerced or manipulated into viewing their material heritage as insignificant. This was made evident amongst select study respondents who had 'stolen' away heritage to save it from destruction, and amongst several departments that have built isolated collections away from public access areas. Staff have and still hold individual pieces of departmental heritage even though a larger museum exists that can offer specialised protection and preservation.

The active collection and preservation of heritage by individual staff members and departments is suggestive of several things (page 206). One is that trust in the management of their heritage is low. Hospital material heritage has supported a selective heritage discourse that they have been intentionally excluded from through the omission of their story. They are yet to trust those external to their department with their heritage and by extension their organisational story and experience. By continuing to hold onto and store those material objects suggests they still feel excluded from the wider historical narrative and so are required to actively support their own narrative. This idea is further evident in the development a specific nursing collection, that grew to become a dedicated museum. The selective heritage discourse has forced staff to actively engage in collections management in order to seek organisational legitimacy and to ensure the continuation of their departmental legacy.

A second point to emerge from staff member collection behaviour is the recognition of their material heritage as having important non-use socio-cultural historic value. Recognition of those non-use existence, option and bequest values identified by Throsby (2007) suggests deeply rooted feelings of departmental and role connectedness and bondedness manifesting itself through the

preservation and retention of material objects (page 166). These actions support Duroust's (1932, cited in Belk 2012, p. 317) argument that 'objects or ideas in a collection must be valued for more than their utilitarian or even their aesthetic qualities'. While they may have initially been identified as primarily possessing utilitarian value, they undergo a legitimisation process where their value is transformed from what Belk (2012) describes as the mundane to the sacred. In selectively discarding heritage and by extension organisational experiences, wider organisational collection behaviours have caused staff members to actively engage in the process of heritage formation in order to protect their organisational identity. RPA heritage then is also a constructed identity referent again used to seek organisational legitimacy.

Identity referents as developed by Albert and Whetton (1985) are those central, distinctive, and enduring organisational traits. To continually identify with a department, staff members chose and continually choose to hold onto heritage thereby providing an identity referent and anchor to their unique organisational experience. This finding supports those of Shnapper-Cohen et al. (2023) who determined that departmental identity is the most prominent form of social identity within a hospital. Due to cultural differentiation resulting from organisational streams and specialities, staff most strongly associate and identify with one another through their departmental connections. Findings from this research suggest heritage is an additional organisational artifact that further supports the development of departmental social identities.

A third finding to emerge from departmental collecting underpins the selective heritage discourse perspective in that some departments have been identified as showcasing material with high associative value. These isolated small collections, although departmentally specific, again exclude wider departmental experiences to focus on specific clinical pioneering and developmental achievements. This evidence serves as a micro example of selective heritage discourse, and further demonstrates that the organisational forces exerted from hierarchical power structures within RPA identify who is and who is not significant across the organisation. The counterargument to this position however should be noted. Health care facilities like large research hospitals are unique organisations that will always be hierarchical institutions in that they are institutions critical to the health and well-being of society. Quaternary research and treatment hospitals like RPA require levels of medical science expertise that should and most probably will always remain venerated and elevated above that of other professions. That said, there are ways in which the AHD can be reframed to minimise or counter the impacts of hierarchical power structures, which will be explored later in the chapter.

Further study findings that support notions of heritage as a process and a performative management tool are evident in participant responses to the deliberate and strategic placement of heritage across the organisational facilities. When staff actively use heritage areas during events or passively through daily movements across RPA, values and expectations are overtly reinforced and managed through the presence of heritage artifacts. Heritage artifacts convey traits outlined by Graham et al. (2005) that provide the respect and status of antecedence, that underpin continuity and stability, and that provide an unbroken organisational trajectory connecting the past with the future in the present. They provide a central platform that attempts to reconcile individual fractured identities within a larger organisational identity. They are also attempts at managing organisational member behaviour. The mystique, prestige, and sense of gravitas engendered by material heritage engagement leads some staff members to experience an intangible unspoken need to be the best and to strive (page 186). They are inspired and motivated to excel, and by excelling join what is presented to them, through the image of material heritage, as an elite level medical institution. Engagement with heritage constantly reminds them that they are at RPA, a place that produces the best staff and best outcomes for patients, and therefore their emotional response and behaviour is influenced and gently manipulated through the presence of heritage.

Heritage is underpinned by notions of expectation that comes in two forms. The first form relates to heritage generating expectations in staff of the Hospital. Expectation meaning what they should 'expect' to experience and encounter as an organisational member of RPA. They are employed at an elite level organisation; and therefore, can reasonably expect elite levels of performance from the organisation. Here again the concept of heritage as a benefit and burden are returned to. The reality surrounding employment at RPA may greatly vary from the image presented through the presence of heritage and those surface level manifestations of organisational culture.

The second being that heritage has the capacity to generate feelings of expectation regarding notions of professional excellence (page 200). In other words, by working at RPA you are expected to strive to achieve above average or outstanding outcomes in your field. Heritage then exerts additional pressure and force across layers of organisational culture. These findings support Trice and Beyer's (1984) view that cultural layers are interdependent, and are not so easily separated as Schein would suggest. Schein (2017) proposes that physical space and buildings, and stories about important events and people, are secondary articulation and reinforcement mechanisms used by leaders to embed values, beliefs and assumptions that shape culture. This research demonstrates

that heritage is frequently used as a primary articulation and reinforcement mechanism. Findings also support Martin's (2001) view that artifacts and values both reflect deep assumptions and are not superficial, as meaning is entirely dependent on interpretation, which this research has demonstrated to be complex and multivariant.

While the first layer of organisational culture is generally perceived as challenging to decipher, heritage as an organisational artifact has provided much insight into deeper cultural circumstances and behaviour. Findings of this research support Maalouf's (2011) argument that heritage values are transmitted both vertically and horizontally. Through the active and passive use of material heritage, RPA organisational values, behaviours and expectations have also been vertically and horizontally transmitted through all three layers of culture. The vertical transmission of heritage values occurs through the presence and maintenance of both built and movable heritage, and through the use and constant reinforcement of rhetoric associated with RPA's history and heritage. As outlined in Chapter 2, the organisational espoused values and beliefs are overtly displayed and expressed through documented organisational philosophies, management strategies, strategic plans, and goals that are all supported by heritage imagery. The RPA website (Sydney Local Health District 2023a) promotes more than '140 years of Service' and language including 'Pioneers in Patient Care', 'reputation for excellence', and 'pioneering innovative techniques'. All themes are connected to or directly derived from a historic perspective supported and articulated through the use of heritage symbols and first layer cultural artifacts.

These themes are further reinforced by public statements like that present on the Queen Elizabeth II Building which reads 'RPA: Pioneers in Patient Care' and a modernised image of the Hospital emblem and royal crest. Through the use of heritage, values and beliefs that emerged from foundational philosophies including those developed during the foundation of RPA Hospital, have been strategically supported and strengthened across time. These values and beliefs suggest 'this is what we've always done, and this is what we will continue to do'. Such rhetoric are symbolic attempts at advancing organisational reputation and legacy through strengthening the Hospitals image. Reputation and legacy are both then defined by the presence of hospital heritage which provides credibility and integrity though permanence which then engenders trust. Trust by organisational members and trust by patients and the public. Through this, the organisation uses foundational values as an historic identity referent to define the future. Innovation, industry leadership and the Hospital's organisational future are interwoven with notions of historic innovation and industry leadership.

The deepest layer of culture, described by Schein (2017) as invisible, intangible and usually tacit, are the deeper core values and basic underlying assumptions held and shared by organisational members. These attributes shape behaviours and have persisted over time. Basic underlying assumptions are derived from unspoken perceived expectations generated from an established history, and again the presence of material organisational artifacts. However, a deeper analysis into tangible heritage suggests they are also stores of identity and cultural capital. The deepest value associated with heritage and history lies in an ability to compound in value. As the organisation grows older, the core values and basic underlying assumptions embedded within the organisation grow stronger. Heritage can then be viewed as a stock of organisational capital that grows more complex and becomes more deeply entrenched with organisational values over time. Authenticity and legitimacy in turn are sustained and strengthened as a result.

In contrast to this finding, some staff questioned the legitimacy of this perspective by interrogating the perceived nature of credibility (page 196). Using heritage to underpin organisational reputation and prestige is perceived by some as not evidence based but an attempt at image management and manipulation. The use of heritage in some circumstances has been viewed as window dressing and an exercise in branding. Hospital areas with high concentrations of heritage provide access and engagement points designed to engage a single emotional response that then help frame a desired attitude and behavioural response (page 223). While heritage branding has to date been utilised as a marketing tool focussed on for profit organisations and institutions like universities attempting to differentiate themselves to customers, it is evident that RPA relies on and actively engages with its heritage to manage and control its image and by extension, reputation, in pursuit of organisational legitimacy. Further, that study respondents identified and discussed all five dimensions of brand heritage described by Urde et al. (2007, p. 7): 'track record, longevity, core values, use of symbols and … an organisational belief that its history is important'. Heritage at RPA is used as a strategic asset designed to leverage trust through projections of authenticity and uniqueness. RPA Hospital relies on the projection of authenticity to generate patient trust in the same way private sector companies develop and utilise branding strategies.

Together, each of these findings contribute to the research into heritage as an image development tool, a branding device, and a management control mechanism used to shape organisational culture and identity. Hospital leadership strategically use heritage to 'introduce, reproduce, influence and legitimise the presence/absence of particular discourses' (Alvesson & Willmott 2002, p. 628). When

poorly managed, heritage use leads to increased cultural differentiation and identity fragmentation. By consistently revisiting heritage, the organisational past is used to reinforce both the present and the future creating a richer and more complex organisational story. This then provides a competitive advantage that attracts research partners, helps develop new funding streams, and attracts what are considered elite level staff, which then together assist in the realisation of a projected image and reputation.

Heritage Operational Impact

The presence and use of heritage at RPA Hospital poses numerous operational complexities that study respondents further identified as offering both advantages and disadvantages. Central to these issues was the tension and conflict surrounding RPA as a modern quaternary hospital, and RPA as a heritage organisation. The impost of heritage spaces on operational effectiveness was widely discussed with several buildings deemed not fit for purpose or requiring significant upgrades in order to function without constant intervention. These issues were discussed as having significant downstream effects such as preventing hospital best practice through inadequate infrastructural arrangements and a need for constant building maintenance. Such maintenance was described as inconvenient and often not performed in a timely and unobtrusive manner. This caused dissention amongst staff who then viewed built heritage spaces as museums and spaces not appropriate to a modern hospital (page 215). Further, that the presence of heritage was viewed as impeding the development and modernisation of RPA. Through the retention of built heritage spaces and movable heritage, RPA, in their view, couldn't effectively change. Change is a central requirement if a hospital is to continue as a complex, adaptive system. These views add to the literature focussed on the financial and operations challenges faced by large public hospitals. Healthcare institutions have a responsibility to ensure resources are appropriately and responsibly managed, and that adequate governance instruments are developed and adhered to. Several study respondents suggested this was not occurring at RPA, impacting both staff operational capabilities and patient outcomes.

The preservation and degradation of the RPA heritage buildings, spaces and statues contains negative as well as positive implications for the image and reputation of RPA. Degraded heritage was noted as impacting on patient and staff perceptions of the Hospital (page 222). Respondents questioned the perceptions held by patients surrounding hospital services that occurred in degraded spaces. Findings suggest that staff attitudes and behaviours were influenced by degraded heritage infrastructure. Hospital environments not appropriately maintained by hospital management teams led to a reduction in respect towards hospital facilities. This had a flow on effect of impacting staff

motivation with staff inspiration and levels of engagement diminished. Under these circumstances, staff departmental identification became strained, and the larger organisational identity once again fractured between the RPA of the past and the one of the future.

Conclusion

In this chapter, the key significant findings of this research have been re-examined with a view to the information and conceptions explored in Chapters 2 and 3. This thesis posed the research question: ***What is the meaning and value of organisational cultural heritage to Royal Prince Alfred Hospital*** Heritage has been demonstrated to provide both significant advantages and disadvantages to Royal Prince Alfred Hospital. Its presence and use present benefits and burdens suggestive of an organisation experiencing cultural and identity conflict. While some aspects of this conflict are institutionally derived, RPA heritage as an organisational artifact, has to some extent been found to further underpin and deepen this conflict.

The key themes that emerged from this study provide insight into the overarching organisational meaning and value of heritage to RPA. Firstly, RPA Hospital heritage contains the power to include and exclude organisational members, valuing and devaluing them though selection and use. Secondly, RPA heritage can be used as a managerial control mechanism that influences culture, identity, and organisational behaviour. Lastly, RPA material heritage impacts hospital operational processes and practices. The central and underlying theme that emerged suggests that RPA heritage offers varying and contested views surrounding the meaning and value of heritage.

Chapter Seven: Conclusion

The aim of this study was to investigate and develop a stronger understanding of the non-economic meaning and value of material cultural heritage at Royal Prince Alfred Hospital. By exploring the perceptions of 32 participants, staff members and volunteers, through a lens of grounded theory method, and known frameworks and theories surrounding heritage, organisations and hospitals, the extent to which heritage is a value contributing asset of the organisation's capital was exposed and critically analysed. This chapter concludes the thesis critically reflecting on the completed study by exploring the implications for policy and practice at RPA, exploring the limitations of the study, and offering ideas on areas for future research.

As outlined in Chapter 1, there is increasing pressure on public healthcare institutions to effectively manage their resources in a changing environmental climate, and with a growing population base across metropolitan New South Wales. Where resources are allocated and how they are managed requires ongoing justification, particularly when a service or hospital component might be viewed as peripheral or even irrelevant to the delivery of effective healthcare. The material heritage of RPA Hospital is one such organisational component that impacts upon many aspects of hospital operations. Research surrounding this impact, and into hospital heritage meaning and value is an unexplored field in both the heritage and management studies literature. Numerous private and public organisations have been identified as collecting and preserving their heritage, but few have included hospitals. Further, there is also a significant knowledge gap in the literature regarding the value of heritage within wider organisational settings. Heritage is acknowledged as being used as an image development tool and for branding and marketing purposes, but such investigations have focussed on for profit private sector brands and companies where brand differentiation is the primary goal.

Profitability is not the primary goal of public healthcare institutions however productivity is central to driving the delivery of high value healthcare. Productivity is greatly influenced by environmental factors including the built environment, the presence or absence of organisational artifacts, and their impact on organisational systems and processes, and people and communities. Large quaternary public hospitals are complex adaptive social constructions containing a myriad of functions, and numerous clinical and non-clinical staff members working to achieve a diverse array of outcomes. With a large workforce operating twenty four hours a day, seven days a week, across a large campus with numerous buildings constructed and continually reshaped and refurbished over 141 years, the presence of heritage at RPA adds an additional environmental component that this

thesis found offers both benefits and burdens to the organisation. Heritage is a contested notion under any circumstances and is no different framed within an organisational setting. This research however finds that contestation is significantly heightened within an hospital setting as the benefits and burdens were found to be significantly shaped by organisational member perceptions of heritage and their perceived impact on hospital operations. Further, that the presence and use of heritage greatly shaped member perceptions of the organisation, impacting on organisational culture and on constructions of departmental and organisational identity.

Implications for Policy and Practice

The findings of this study surrounding the nature and value of cultural heritage at RPA have provided significant insight that may be used to inform the development of future organisational policies and practices. Issues were identified at RPA Hospital with inadequate recognition and selection of heritage material, and with the proceeding management of that material. Management in this sense includes the strategic use of heritage by the organisation. These issues could be mitigated, to some degree, by effective policy development. Government organisational responsibilities surrounding cultural heritage are in principle supported by policies, strategic frameworks, codes of conduct and management guidelines that guide decision making. The SLHD has one guideline regarding the management of heritage material at RPA titled 'Museum and Archives Collection: RPAH_GL2018_007'. Within the SLHD, compliance is mandatory regarding policy, policy compliance procedures and documented procedures. Guidelines, however, are formal statements developed to assist effective decision making and to support staff in undertaking their duties. The footer of the RPAH_GL2018_007 document reads 'Compliance with this Guideline is Recommended' (Sydney Local Health District 2018, p. 1). Guidelines are not policy and therefore compliance is not mandatory. The district executive should consider the development of mandated policies that prevent the intended or unintended disposal of portable cultural heritage, and of the degradation of built heritage and heritage spaces through neglect. This would ensure heritage is collected, studied, preserved and/or disposed of by a suitable professional with archival and heritage knowledge and experience.

This study has also highlighted the fractured nature of heritage collections and organisational memory. Respondents identified that heritage and documented history at RPA have failed to adequately capture all organisational narratives and experiences across time including those voices present before colonial settlement. The key findings of this thesis suggest that the differentiated culture and complex nature of multiple hospital identities could to some degree be mitigated or

reconciled through significant changes in heritage representation. The addition of heritage that represents a wider corpus of hospital roles, gender and socio-cultural backgrounds would generate a wider sense of inclusion mitigating the aggressive nature of hospital hierarchical arrangement. Further, strategic use of heritage and history can assist new member organisational orientation and relationship development and can support organisational continuity and the CED components of identity construction. The gig economy has rapidly emerged to expand across several sectors disrupting established markets, firms and workplace practices including the healthcare sector (Healy et al. 2017; Kelly 2020). Further, 'poor recruitment and retention of nursing staff in healthcare settings', has led to high staff turnover rates (Wilson et al. 2016, p. 90). Opportunities to connect short-term staff with an organisation by fast tracking the development of the organisation–member relationship are extremely important. Effective heritage use can again mitigate early sub-cultural development through wider organisational identification. This might be resolved through departmental or locational engagement of staff aimed at celebrating and commemorating their roles across the RPA through representations of heritage.

Another way in which the presence and strategic use of heritage across the RPA can be positively strengthened is by the development of instruments that ensure marginalised organisational member voices are purposefully captured, archived, and protected. These same instruments could ensure that marginalised voices are present and active when determining the nature and value of organisational cultural heritage. This could occur through the establishment of a heritage advisory committee at RPA, like that of the RPA Sustainability Committee. Like the sustainability committee, an RPA heritage committee could meet bi-monthly to discuss and drive heritage matters across RPA. A Terms of Reference would be established outlining aims and goals and would frame committee membership ensuring an inclusive membership derived from across the organisational base. This committee would then ensure no one organisational department or person controlled the collection, management, and use of RPA heritage.

The other key finding that has implications for practice involve those superficial views of heritage identified by respondents. Degraded heritage should be prioritised for significant and meaningful repair and non-clinical heritage environments should be protected and expanded as staff member mental health and wellbeing break out spaces. The artistry of heritage is celebrated by staff as much as the historical significance is recognised. Heritage spaces should then be strengthened and expanded to engage staff in pursuit of this.

Study Limitations and Future Research

This research used in-depth one on one interviews and focus group sessions aimed at penetrating the deeper perceptions and views surrounding heritage at RPA. While the research findings proved complex and diverse, like all research, limitations and weaknesses were discovered (Creswell & Poth 2018). Some were identified early in the research and were accounted for, some cannot be accounted for due to limitations or pressures externally applied to the study, and others went unidentified until research findings were analysed and interpreted. The following section outlines these limitations and offers areas for further research.

While thirteen interviews and three focus group sessions proved adequate to reach study node saturation, a wider and more diverse sampling body may have provided additional novel data. A key theme that offered contentious and divergent organisational and member perceptions of heritage value was that of the selective and exclusive nature of RPA heritage. The absence of Environmental Services, Capital Infrastructure and Engineering, and Aboriginal Health staff from the sampling body due to the SLHD ethics requirements, is evident across the findings. While the absence of those staff members was identified as a possible shortcoming early in the study, findings now positively confirm their absence as a study limitation. As noted in the Study Limitations section of Chapter 3, CIE staff are instrumental to both the protection and destruction of heritage buildings, spaces, and movable heritage. The ongoing management and maintenance of heritage requires active strategic engagement from CIE staff. The physical challenges concerning hospital operations within heritage aged infrastructure was identified by several respondents within the Operational Challenges core category. Therefore, the inclusion of CIE staff may have offered additional insight and further depth of understanding surrounding the complexities associated with the presence of heritage within a hospital.

Staff from the Environmental Services department, who manage waste and recycling and are central to hospital sanitation and infection, prevention and control procedures would also have offered novel perspectives surrounding heritage at the Hospital. Observational evidence suggests cleaning and navigating heritage infrastructure proves challenging for cleaning staff. Further, that providing additional resources to clean and protect heritage installations and movable heritage located across the campus may apply additional pressure to cleaning services. Finally, members from the Aboriginal Health team, with their knowledge of Country, cultural values and traditions might also have provided further novel insight into conceptions of exclusion and diminishment, colonial history, Euro-western governance, urban design, and land management.

A further limitation encountered during the research recruitment process was concerning the self-selective nature of recruitment. Those staff members willing to allocate personal time to participate in the study might be perceived as holding positively biased views towards heritage. The nature of in-depth qualitative interviews and focus group sessions however proved beneficial as those staff members who self-identified as liking history and heritage, also proved open and forthcoming regarding their negative views of RPA heritage. This can then also be viewed as a study strength in that those respondents who engaged in the study prepossess adequate insight and critical thinking surrounding heritage meaning and value.

The final limitation identified in the study involved that of the principal researcher. There were several failures of interview technique resulting from interviewer inexperience as navigating the insider researcher position proved more challenging than anticipated. Upon reflection, the researcher may have overly restrained from probing too strongly with follow up questions, for fear of influencing responses by offering articulations and frameworks of understanding that participants may not have developed without assistance. This has proven to be a study weakness. While the researcher position is openly acknowledged in the methodology, an analysis of the research data highlights moments where additional follow up questions to participant responses or statements could have further enriched the data, particularly in relation to the selective heritage discourse. Although some follow up probing questions did take place, participant responses were limited to overarching statements surrounding the patriarchal nature of 20th century society and an acceptance that male dominated and privileged materiality was an expected outcome of that time. Further investigation into participant thoughts regarding how this might be corrected could have provided deeper insight into organisational identification. Further, when staff members felt included and represented through heritage, a deeper investigative inquiry may have provided greater insight into the implications of this. A more complex understanding regarding the way this impacted their daily operational activities beyond superficial surface level emotional responses suggesting they felt 'good' might have provided further insight into organisational and departmental identification and the socialisation processes that underpin the development of organisational culture. Finally, heritage was identified as generating notions of expectation. Follow up questions into the nature of this expectation may have provided further insight and information surrounding the impact of this on staff performance, attitude, and modern workplace themes such as mental health and wellbeing.

Regardless of these limitations and weaknesses, the study has proven rich in data providing substantial and meaningful insight into the meaning and value of heritage at RPA Hospital. The findings are substantial regarding the implications of the presence and use of heritage within an organisational setting. Further, the gaps in knowledge surrounding the absence of CIE, Environmental Services and Aboriginal Health staff in the study each provide opportunities for further investigation and research into the impact of heritage on healthcare organisations and the effective delivery of healthcare.

A further area presenting avenues for additional research has emerged in the recognition and celebration of heritage artistry. There has been 'increasing interest in the use of arts in the healthcare context' over the past 20 years (Wilson et al. 2016, p. 90). This includes a significant increase into the effects of the arts on health and well-being, prosocial behaviours within communities and social inclusion (Fancourt & Finn 2019). Heritage viewed and valued for its aesthetic and artistic value proved a common finding and theme across the data in this thesis. Further investigation into the area of hospital art heritage and patient health outcomes, and hospital art heritage and staff mental health and well-being may offer significant and invaluable insight into the use of heritage as both a passive non-use environmental artifact and as an instrument for active engagement.

Wilson (2016, p. 100) adds 'there is a growing body of evidence which strongly suggests that introducing arts activities into a variety of different healthcare settings can have a positive impact on the health and well-being of patients and service users, and healthcare professionals hold predominantly positive perceptions of their use'. Movable art heritage held by the museum may also present additional opportunities to support art in health programs that both support positive patient and staff outcomes. Stuckey and Nobel (2010, p. 256) argues that 'art helps people express experiences that are too difficult to put into words, such as a diagnosis of cancer', and art therapy has been demonstrated to assist in the treatment of mental illness and serious symptoms of trauma (Slayton et al. 2010). These bodies of research can be further developed through the inclusion of art heritage as an engagement medium.

This study is by no means limited to health care facilities or government organisations, or to organisations with a lengthy history and heritage. The results of this study demonstrate wider implications for all organisations with heritage collections or that use heritage and history for

strategic communication purposes. As noted in Chapter 1, the biggest enterprises in the country were and still are government organisations. Large public institutions like those associated with education and transport could apply the findings of this research to their organisations and to their heritage collections. Further, private sector organisations like the various sporting museums mentioned in Chapter 1, should look to ensure their collections are representative of the history of their sport. The continued growth and development of women's sport into sporting fields traditionally dominated by men requires an inclusive approach and accurate representation of the history of that sport. Organisations with heritage must ensure that organisational heritage is representative of all organisational experiences and that these representations must be actively engaged with through continual revisitation, assessment, and revision. This might entail active research, investigation and analysis of heritage that initially proved limited, but could with careful planning and consultation be retrospectively celebrated. This will ensure organisational heritage remains an appropriate reflection of the surrounding socio-political environment in which it exists, and not an organisational artifact reflective of a limited time and space.

Conclusion

Earlier in this thesis, Riganti (2003, p. 131) was quoted stating that 'monuments and historic areas can be regarded as a stock of social values that need to be preserved and enhanced in order to increase the social capital of a specific society'. That same assertion can be applied to cultural heritage at Royal Prince Alfred Hospital. This research finds that heritage offers both social and by extension organisational capital that, when used effectively, offers extensive opportunities for value-oriented action. Key to Riganti's (2003, p. 131) statement however is the word 'enhanced'. Only by recognising and acknowledging that there is a need to not only preserve heritage social values but to enhance them, can heritage provide meaningful social capital. Without constantly revisiting heritage meaning, reinterpreting heritage value, and redefining conceptions of heritage, organisational social capital remains limited, confined and poorly realised. Further, the presence of heritage within an organisation, even in a non-use capacity, can cause organisational damage through division and fragmentation. Organisational heritage value must be continually enhanced by being discarded and embraced as required by the present, a present that reconsiders the past with a view to the future.

This research concludes that there is value in determining and understanding heritage and history to an organisation of any age and any type. Understanding, acknowledging, and respecting the organisational journey, foundational stories, physical artifacts, and organisational memory, which are all demonstrated components of identity, culture, and image, together represent an opportunity

to create organisational value. In turn this value represents organisational capital that manifests itself through stronger member–organisational connections, and a stronger organisational identity and culture. In essence, heritage and history are valuable organisational management tools that when used effectively can underpin an organisation and can be used to strengthen organisational values. The preservation and presence of history and heritage can in such circumstances take on an important role in establishing links and connections for organisational members. As is the case at RPA, it can also lead to the significant negative outcomes through the marginalisation and exclusion of organisational members. The selective nature of RPA heritage represents a selective discourse that has implications for organisational culture and identity through the inclusion and/or exclusion of organisational members. Heritage was found to support the development of organisational sub-cultures with values, attitudes and behaviours that differ from management.

Failure to recognise these issues greatly devalues the power of heritage and limits the possibilities of that power. Failure to implement effective management instruments, policies, strategies, and codes of conduct surrounding organisational cultural heritage puts organisational heritage and the organisational story at risk. This risk has a significant flow-on effect that may include alteration or loss of organisational identity, alterations to culture, image, branding, legitimacy, and an erosion of confidence in the organisation. Healthcare organisations like RPA, seek almost above all else, legitimacy, pursuing both pragmatic and cognitive legitimacy. While legitimacy provides some measure of brand and image insurance, it also provides a platform on which new and old organisational members build culture and identity. In this study the Hospital central identity and image are intricately bound to the organisational material cultural heritage. The heritage of RPA represents a strong organisational symbol that ensures recognition, continuity, trust, respect, and legitimacy that this study demonstrates must be protected and preserved but continually reconsidered and enhanced to embrace past, present, and future generations of hospital staff.

Appendices

Appendix A Rough Data Coding

Emotional	Defining CH	Meaning of CH	Value of CH	Purpose of CH	Issues with CH	Use of CH
Joy	Personal memories	Pride	Pragmatics	Pride	Sadness	Commemoration
Frustration	Stories	Confidence	Pride	Confidence	Loss of connections	Displays
Loss	Buildings	Longevity	Confidence	Education	Accessibility	In situ physical artifacts
Beautiful	Objects	Patriarchy	Contextual	Tool	Cost	Departmental artifacts
Privileged	External links	Power	Attraction	Data	Space	Departmental heritage
Pride	Institutional connections	Privileged	Education	Information	Time poor	Social media
Visitation guilt	Traditions	Traditions	Tool	Connections	Modernise dissemination techniques	Reputation
Pleasure	People	Reputation	Reputation	Lessons of past	Contentious past	Physical reminders
Unsure why positive	Data	Prestige	Functional	Team connections	Exclusive	Modern CH needs to provide distilled experience
Devastated	Information	Compromise	Secondary resource	Strive	Hospitals hierarchical	Team building exercise
Special resonance with historical objects	Corporate memories	Challenging	Uniqueness	Motivation	Destruction normative	Celebrate departmental anniversary
	Exclusive	Responsibility	Transition	Emails	Indifference	Isolated interest based on department
	Expectation	First impression	First impression	Social media	Communication	
	Photography	Fascinating	Dysfunctional	Patient feedback	Engagement	
	Associations	Change reminder	Memory ritual	Staff feedback	Demolition	

	Unique	Lessons of past	Data		Museum utilisation	
Emotional	**Defining CH**	**Meaning of CH**	**Value of CH**	**Purpose of CH**	**Issues with CH**	**Use of CH**
	Generational	Acknowledgement	Story telling		Taken for granted	Departmental artifacts
	Progressions	Associations	Lessons of past		Generational	Departmental heritage
	Innovation	Generational	Protection		Good balance	
	People stories	Wealth	Personal connection		Modern is boring	
	Buildings stories	Prestige over value	Personal disconnection		Modern is sterile	
	Age	Ownership to few	Team connections		Conflict over pragmatics	
	Time related	Privileged to few	Strive		Positive integrate old in new	
	Wealth	Past people	Motivation		Cost effectiveness	
	Name	Fascination	Time served attachment		Effective space management	
	Colonialism	Curiosity	Staff value		Cost justification	
	Past medical practices	Character	Wealth		Sustainability	
	Living museum	Feelings	Reflection		Practical use	
	Tangible objects	Buildings contribute	Admiration		Obligation	
	Institutional behaviour	Intertwined with RPA image	Goal		Primary purpose only	
	Retrospect	Institutional ways	Organisational leader		Sustainable communication techniques	
	Internal links	Organisational journey	Non-use connection		Institutional behaviours	
	Knowledge	Heritage secondary	Iterations of practice		Damaging institutional behaviours	
	Text	Justifications of practice	Embrace depth of past		Myth	

Emotional	Defining CH	Meaning of CH	Value of CH	Purpose of CH	Issues with CH	Use of CH
	Social knowledge	Preservation a part truth	Personal perspective		Heritage is perception	
	Scholarships	Matriarchal devalued	Departmental perspective		Question diversity valuation methods	
	Patriarchal naming	Magnificent	Member value placement		Elitism	
	Elite male perspective	Reverence	Exposure		Historical view can be obstructive	
	Professions	Awe	Contribution		Constant relocations cause loss of heritage	
	Departmental histories	Authority of standing	Pleasure		Governance	
	Rare	Aura	Continuity		Junior staff disconnect	
	CH is change	History is respected	Curiosity		Tension with primary purpose	
	Emblems	Mystique	Departmental connection		Past lack of care	
	Insignia	Acknowledgement	Positive departmental engagement		Staff are time poor	
	Statements at entrance	Reality reminder	Increased organisational understanding		Conflicting messages about heritage over years	
	Plaques	Uphold standards	Identification		Need to develop new staff history packs	
	Living heritage	Modern is boring	Organisational success		Old–new tension	
	Heritage starts today	Modernisation devalues old	Mystique			

Emotional	Defining CH	Meaning of CH	Value of CH	Purpose of CH	Issues with CH	Use of CH
	Governance change	Emotional reaction	Instructive			
	Fostered behaviours	Locality connection	Morale booster			
	CH is context	Time developed	Inspirational			
	Architecture	Best practice	Social reminder			
	Staff biological lineage	Credibility	Longevity priceless			
	Heritage is reflection	Social reminder	Instilled importance of role			
	Long-standing staff members	Wider political view	Interactions of technology			
	Artifacts	Heritage matters	Adds to staff retention			
	Institutional behaviours	Fundamental desire to connect	Emotionally welcoming			
	CH is physical connection	Embedded behaviour	visual appeal			
	Australian first	Strong personal connection	Relaxation			
	CH is reputational story	Duty	Reputation attracts staff			
	Gardens part of CH	RPA name identity	History attracts staff			
	Research	Area connection	Best practice			
	Personal stories	People transient	Mentoring			
		Executives respect history	Credibility			

Emotional	Defining CH	Meaning of CH	Value of CH	Purpose of CH	Issues with CH	Use of CH
		Staff ownership of history	Positive belief			
		Proud history	Promotional			
		Implications with long history	Community value			
		Prestige not evidence based	Behavioural ripple effect			
		Little time capsule	Non-negotiable			
		Tangible Connections to past people	Life changing			
		Heritage collection a conventional way of thinking	Heritage as capital			
		Heritage is perception	Personal Loyalty			
		Connections can be personal	Time as capital			
		New building soulless	State level value			
		Reflective responses	Reassuring			
		Implications of change	Informative			
		Lens for history obscures balances perspective	Member engagement			
		Unspoken expectations	Good publicity by staff			
		Unspoken expectations	Active use of history			

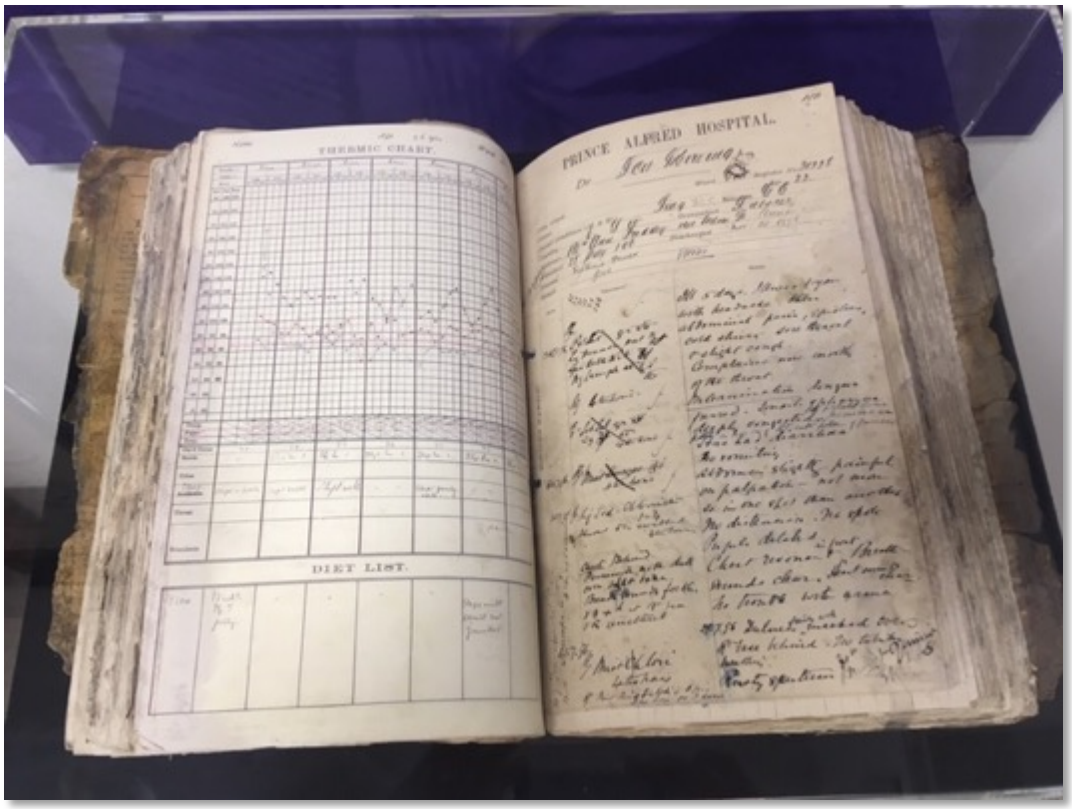
Emotional	Defining CH	Meaning of CH	Value of CH	Purpose of CH	Issues with CH	Use of CH
		Pressure	Prestige attracts excellence			
		Connection loss	Historical continuity			
		Greatness	Myth			
		Justify oneself	Personally continuing a tradition			
		CH assumes new identity	Streetscape diversity			
		Stories in artifacts	Promotes wellbeing			
		Future identity based on past	Promotes mental health			
		Personal identification	Exclusivity			
		Overpowering image	Job specific Staff hospital tour			
		Organisational traditions	Organisational reminder			
		Must reinvent itself	Legacy			
		Street cred requiring reaffirming	Tangible reminders			
		Work practice changes	Objects provide connection			
		Living breathing heritage	Branded objects perpetuate pride			

Emotional	Defining CH	Meaning of CH	Value of CH	Purpose of CH	Issues with CH	Use of CH
		Staff identify with physical facility	Unspoken impact on staff behaviour			
		Changing attitudes to heritage	Non-visibility decreases value			
		Personal memories of childhood	Architectural value			
		Long history of expected behaviour	Stories associated with building designs			
		Increased value in CH recently	Maintain ambiance			
		Stories define the organisational journey	Stories as member conversational starters			
		Social history stories	Increased staff performance			
			Leadership			
			Visibility increases value			
			Museum offers community connection			
			Museum offers monetary value			
			Employment attraction			

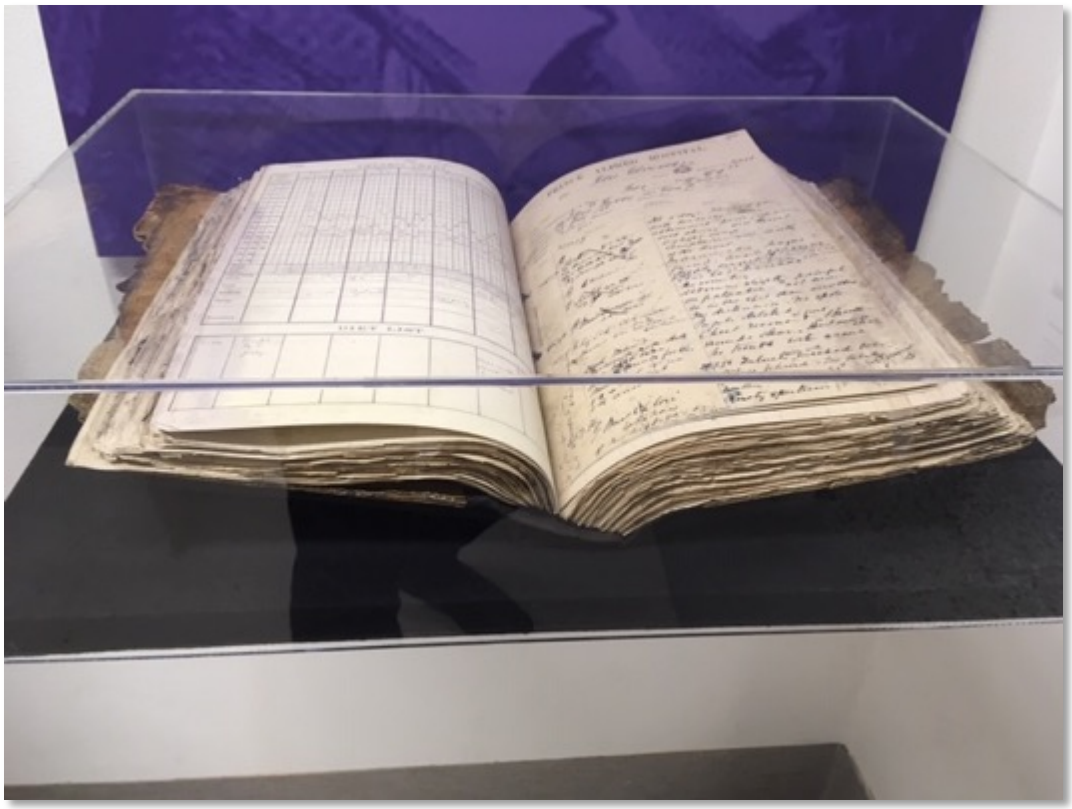
Appendix B Items and Images Presented to Respondents for Review Before Session

Source: Scott Andrews, original photographer unknown

1882 Administration Block Cedar Arches with Donations Plaques
Source: Scott Andrews



Dr Robert Scot Skiving's 1896 Medical Record – RPA
Source: Scott Andrews



Dr Robert Scot Skiving's 1896 Medical Record – RPA
Source: Scott Andrews

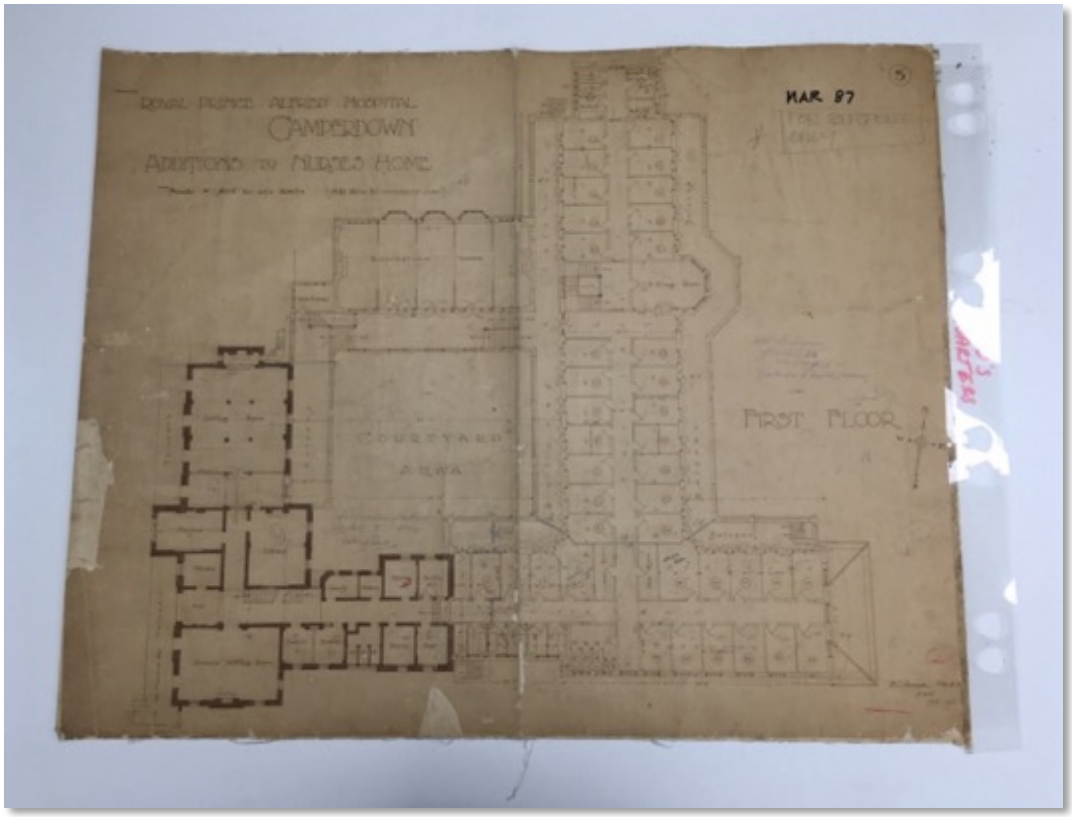
King George V statue located at entrance to King George V Memorial Hospital for Mothers and Babies, today a SLHD administration building.
Source: Scott Andrews

1882-installed stained-glass windows in RPA main entrance
Source: Scott Andrews

Monoaural stethoscope
Source: Scott Andrews

Dr Robert Scot Skirving's timber monaural stethoscope, RPA surgeon, c. 1895
Source: Scott Andrews

RPA single serve milk jugs, c. 1935
Source: Scott Andrews



RPA 1912 Nurses' Home extension schematics
Source: Scott Andrews

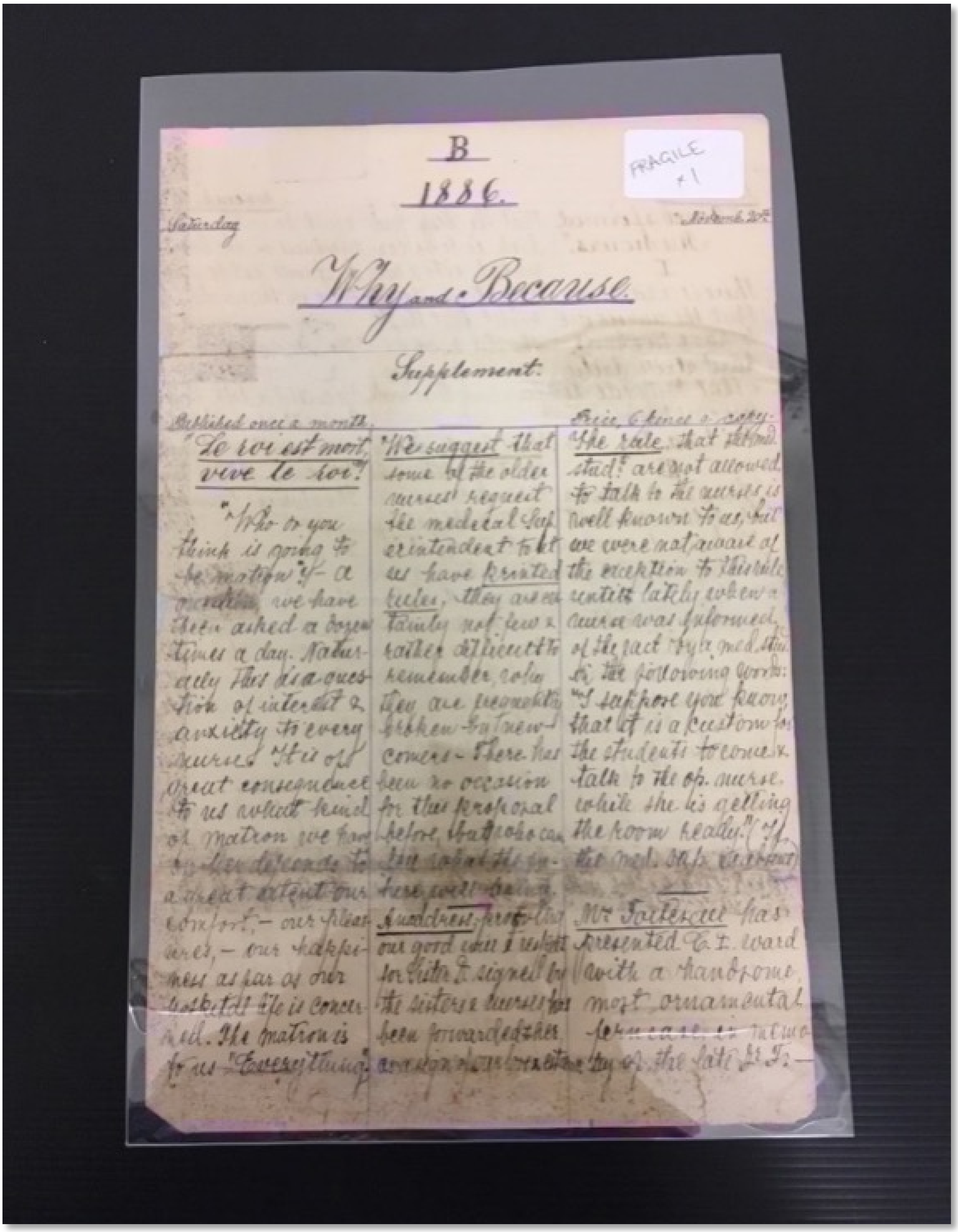
Original cloth-backed print of showing rear view of RPA – c. 1905, 150mm high x 200mm wide
Source: Scott Andrews, original photographer unknown

Original cloth-backed print of showing RPA porter and Porter's Cottage, c. 1905, 150mm high x 200mm wide
Source: Scott Andrews, original photographer unknown

Original cloth-backed print of showing rear view of RPA, C Block and doctors, c. 1905. 150mm high x 200mm wide
Source: Scott Andrews, original photographer unknown

Original cloth-backed print of showing RPA, Hope Ward, c. 1905, 150mm high x 200mm wide
Source: Scott Andrews, original photographer unknown

Original print of showing rear view of RPA, ‘All Staff’, c. 1885, 240mm high x 360mm wide
Source: Scott Andrews, original photographer unknown



B

1886.

Saturday

Why and Because

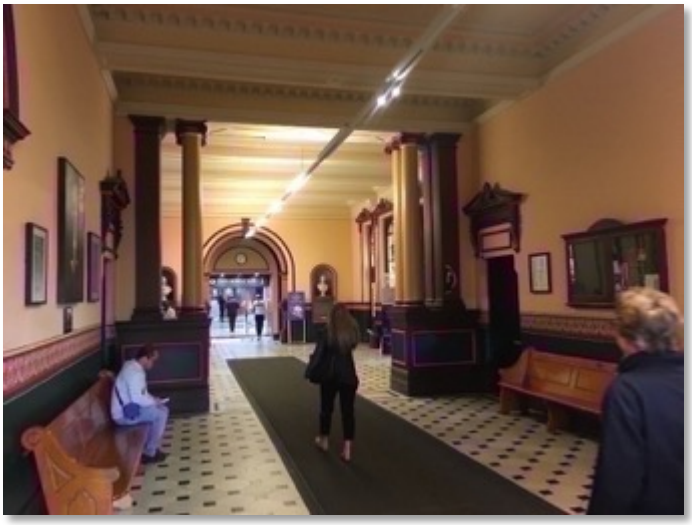
Supplement.

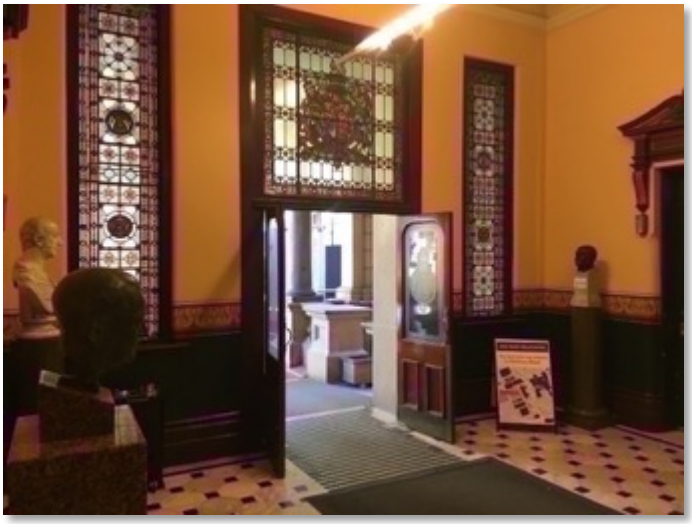
Published once a month.

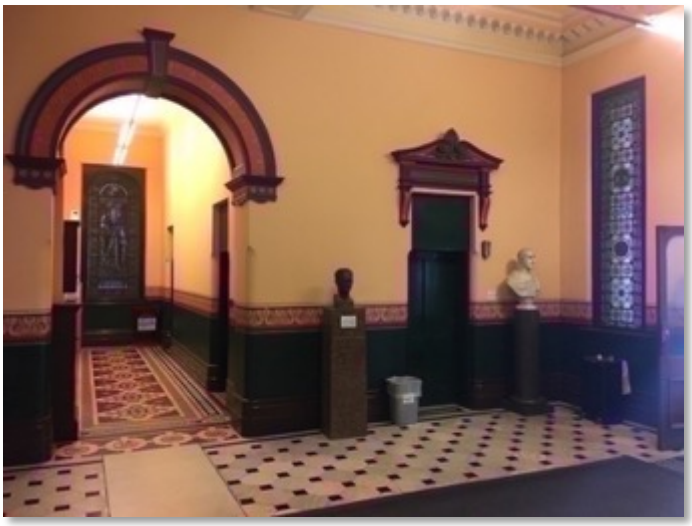
Price 6 pence a copy.

RPA Nurses' Gazette, 1886, 330mm high x 205mm wide
Source: Scott Andrews

Appendix C Images presented during focus group and interview sessions







1882-built RPA front hall and foyer
Source: Scott Andrews

1880-built pathology building (not heritage listed)
Source: Scott Andrews

1880-built pathology building (not heritage listed)
Source: RPA Museum and Archives, original photographer unknown

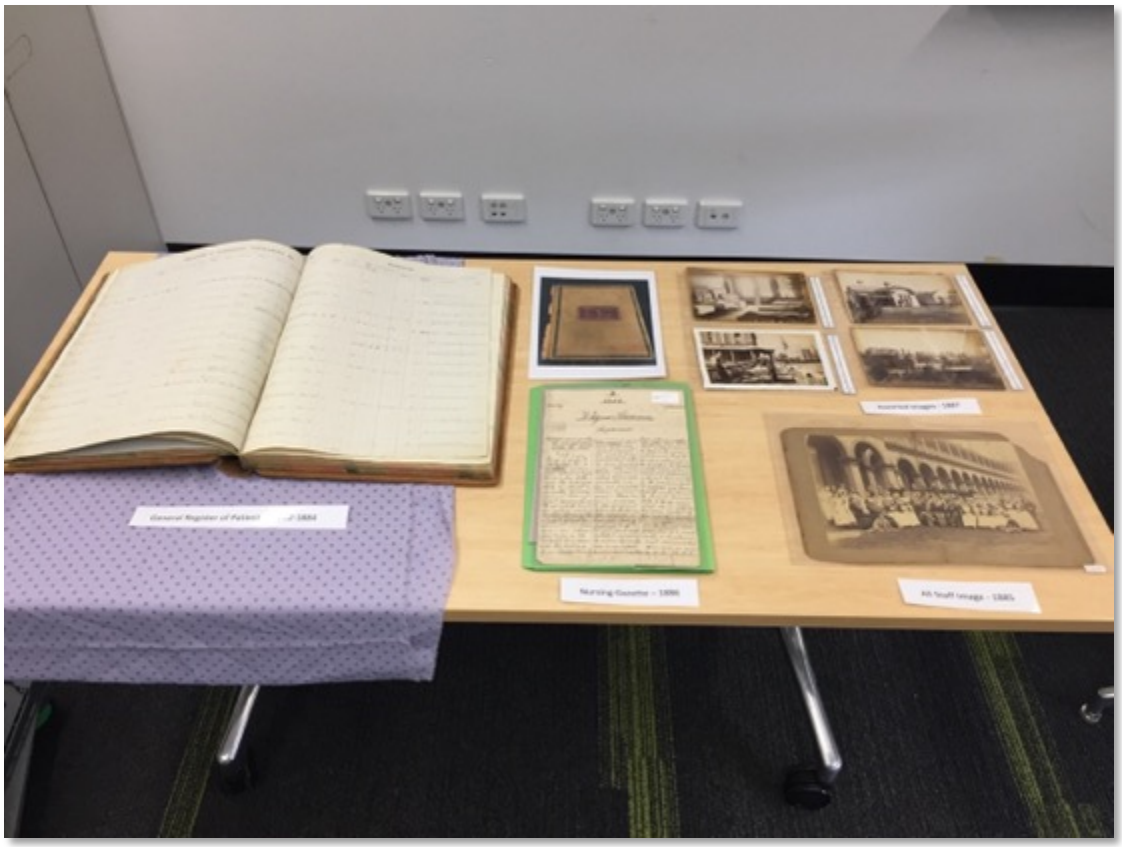
1941-built King George V Operating Theatres located in the RPA Museum
Source: Scott Andrews

1941-built King George V Operating Theatres located in the RPA Museum
Source: RPA Museum and Archives, photographer unknown

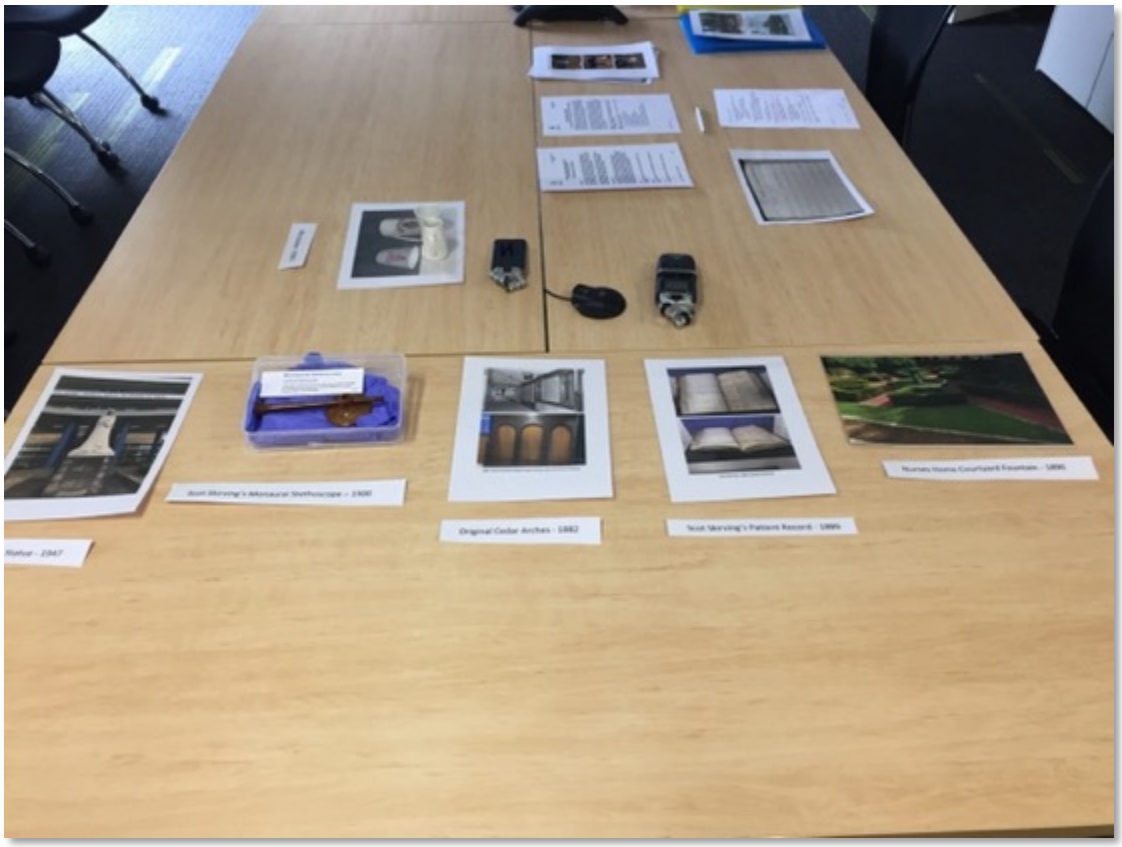
1914-built Nurses' Home quadrangle fountain with nurses
Source: RPA Museum and Archives, photographer unknown

Nurses’ Home quadrangle fountain in 2020
Source: Scott Andrews

Appendix D Artifact Presentation Tables



Source: Scott Andrews



Source: Scott Andrews

Source: Scott Andrews

Appendix E RPA Museum ‘Did you know ...?’ Campaign

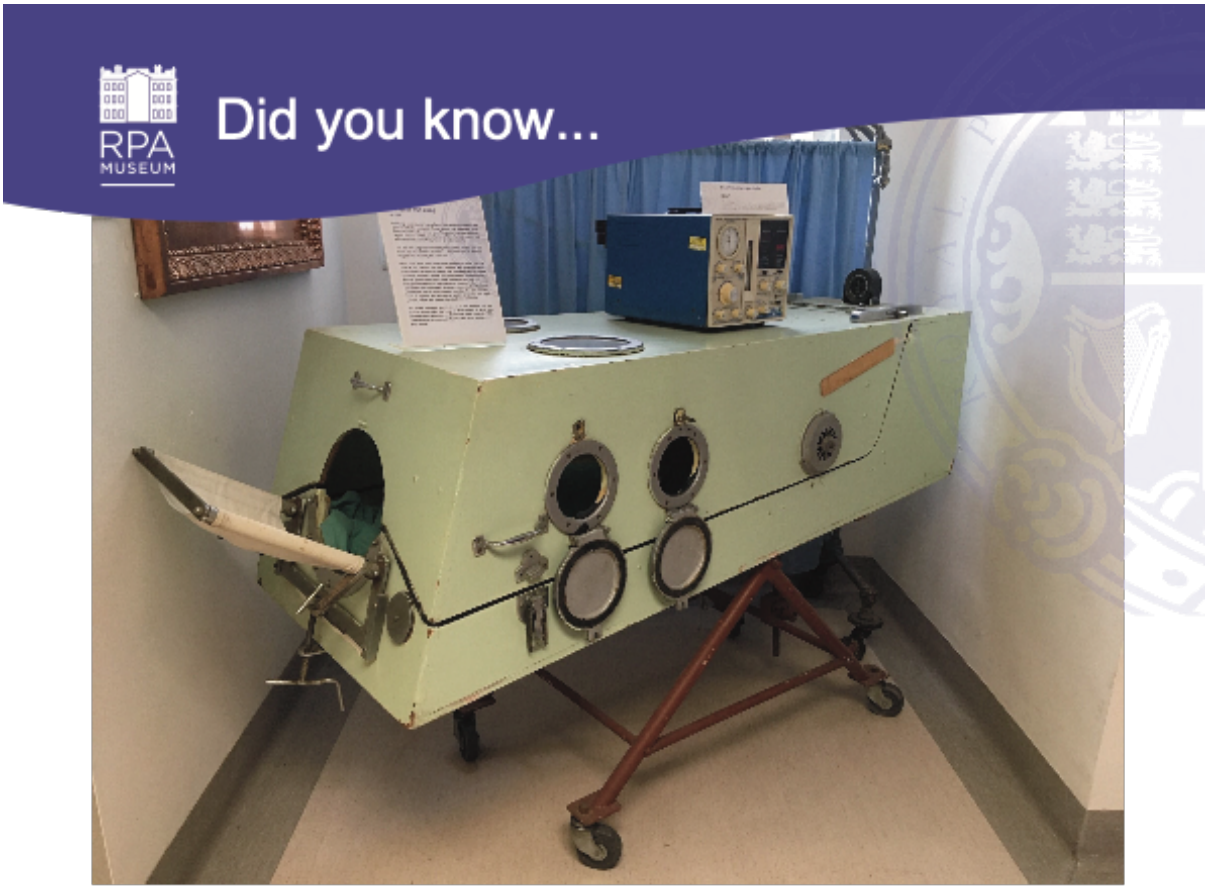


Image: RPA Museum collection

Did you know KGV staff delivered a baby in an iron lung?

King George V Memorial Hospital for Mothers and Babies made NSW medical history in April 1956 when a mother suffering from poliomyelitis gave birth to a healthy baby in an iron lung. The 22 year old mother contracted polio a month prior, and her condition was "so grave that it seemed unlikely she would survive the polio attack".The baby was born while the mother was lying in an open iron lung with a temporary respiratory system attached to her chest enabling a "normal labour". The baby weighed two and a quarter pounds and his condition twelve hours after birth was satisfactory. The last report of mother was that she was "steadily improving".

The 1955 built "Both" iron lung pictured above sits outside the RPA Museum. The Both (pronounced Moth) was invented by Adelaide brothers Edward and Donald Both, founders of the company Both Equipment Limited. The Both respirator was made of plywood, contained an external electric air pump, was highly portable, and was simpler and cheaper to make than traditional models of the time. The model displayed is known as an ‘alligator’ iron lung because its lid opens like the jaws of an alligator to permit easy patient access. Before this modification in the mid 1950’s, patients had to be inconveniently slid in and out like drawers of a filing cabinet.

Australia's first iron lung delivery occurred at Royal Perth Hospital, March 24, 1948. Research suggests it was probably the worlds first.

No 24

RPA Museum ‘Did you know’ digital campaign
Source: RPA Museum and Archives

Appendix F Renal Dialysis Wall History Infographic

Source: Scott Andrews

Appendix G Study Recruitment Advertisement version 1

RESEARCH PARTICIPANTS WANTED

WHAT ARE WE LOOKING AT?

Exploring the value of **Cultural Heritage** at Royal Prince Alfred Hospital.

WHO ARE WE LOOKING FOR?

Employees and volunteers with more than 5 years service at RPA.

WHAT WILL I HAVE TO DO?

1 X 60-90 minute focus group or interview.

HOW DO I GET INVOLVED?

Contact **Scott Andrews**, Manager Museum and Educational Facilities Royal Prince Alfred Hospital on scott.andrews@health.nsw.gov.au or [redacted].

This study has been approved by the Sydney Local Health District (RPAH zone) Human Research Ethics Committee (X19-0119).

Focus Group Advertising, Version 3, 29/07/2019

Appendix H Study Recruitment Advertisement version 2

ROYAL PRINCE ALFRED HOSPITAL

RESEARCH PARTICIPANTS WANTED

WHAT ARE WE LOOKING AT?

Exploring the value of **Cultural Heritage** at Royal Prince Alfred Hospital.

WHAT WILL I HAVE TO DO?

1 X 60 minute focus group or interview.

HOW DO I GET INVOLVED?

Contact **Scott Andrews**, Manager Museum and Educational Facilities Royal Prince Alfred Hospital on scott.andrews@health.nsw.gov.au or [redacted].

This study has been approved by the Sydney Local Health District (RPAH zone) Human Research Ethics Committee (X19-0119).

Focus Group Advertising, Version 4, 15/09/2019

ROYAL PRINCE ALFRED HOSPITAL
A tradition of excellence since 1882

Framing and Valuing Cultural Heritage at Royal Prince Alfred Hospital

INFORMATION FOR PARTICIPANTS

Introduction

You are invited to take part in a research study that will investigate perceptions of value surrounding cultural heritage at Royal Prince Alfred Hospital. There is an increasing appreciation in the value of organisational cultural heritage, but its value is rarely explored and is poorly understood. This study aims to gain an understanding of the value of cultural heritage at Royal Prince Alfred Hospital.

The study is being conducted within this institution by Scott Andrews, RPA Manager of Museum and Educational Facilities as part of the requirements for a doctoral degree at the University of Technology, Sydney. The study is supervised by Dr Stephen Schweinsberg and Associate Professor Linda Leung.

Study Procedures

If you agree to participate in this study, you will be asked to sign the Participant Consent Form, select an interview or focus group day and time, and participate in either one 60-90 minute focus group or one 60-90 minute interview. All interviews and focus groups will be held in Royal Prince Alfred Hospital meeting rooms or offices. The focus groups and interviews will be audio-recorded. All information will be transcribed by Scott Andrews and kept in a non-identifiable manner for analysis. Audio-recordings will be deleted once they have been transcribed.

Risks

The risks of participating in this study include a small amount of time related inconvenience.

Benefits

This research study aims to benefit organisational knowledge regarding cultural heritage.

Costs

Participation in this study will not cost you anything, nor will you be paid.

Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason. Whatever your decision, please be assured that it will not affect your position within the organisation.

Confidentiality

All the information collected from you for the study will be treated confidentially, and only the researchers named above will have access to it. Participant responses will be deidentified in final publications. All data collected will be stored and analysed on a secure REDCap database accessed through Sydney Local Health District and University of Technology, Sydney computer networks. The study results may be presented at a conference or in an academic publication, but individual participants will not be identifiable in any way.

Further Information

When you have read this information, Scott Andrews will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact him on .

This information sheet is for you to keep.

Ethics Approval and Complaints

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney Local Health District. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X19-0119.

Appendix J Participant Consent Form

Framing and Valuing Cultural Heritage at Royal Prince Alfred Hospital

PARTICIPANT CONSENT FORM

I,_____
[name]

of

_____
[address and phone contact information]

have read and understood the Information for Participants on the above named research study and have discussed the study with Scott Andrews.

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, or discomfort and of any implications as far as they are currently known by the researchers.

I understand that the focus group/interview will be audio-recorded, and I agree to this.

I understand that the focus group/interview will be between 60-90 minutes in duration.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

Please select one of the below. You will be contacted to confirm a date and time.

Focus group ☐
Interview ☐

NAME:_____

SIGNATURE:_____

DATE:_____

NAME OF WITNESS:_____

SIGNATURE OF WITNESS: _____

DATE:_____

Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason. Whatever your decision, please be assured that it will not affect your position within the organisation.

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Further Information

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Appendix K Session Interview Guide

ROYAL PRINCE ALFRED HOSPITAL
A tradition of excellence since 1882

Focus Group Outline

Framing and Valuing Cultural Heritage at Royal Prince Alfred Hospital

Introduction

Good morning/afternoon. Thank you very much for taking the time to participate in this focus group. My name is Scott Andrews and I am the Manager of Museum and Educational Facilities at Royal Prince Alfred Hospital. I am conducting this focus group in order to develop ideas surrounding cultural heritage at Royal Prince Alfred Hospital, and to gain insight into perceptions, value and meaning to organisational members. Please refer to page two of this document for a more thorough research outline.

I will ask the group questions that you can answer however you like. You will have the opportunity to respond to other participants' questions and comments during the focus group as well. All of the information I collect in this focus group will be keep confidential. The focus group should take no longer than 90 minutes to complete. I will also be audio-recording the session so that I can concentrate on your responses and refer back to them during analysis. Is this okay with you? If there are any questions that anyone wishes to skip or come back to at a later time, or if you need to take a break at any time, please let me know. We can also cease the session at any time if anyone becomes uncomfortable. Are there any questions before we begin?

Method

Four focus groups containing six participants held at Royal Prince Alfred Hospital will workshop and explore perceptions of cultural heritage.

Questions

Focus group questions will include the below;

1. What does cultural heritage mean to you?
2. What is RPA's cultural heritage?
3. What does this object mean to you? – show 1882 admissions book.
4. What value is there in RPA's cultural heritage?
5. How is RPA's cultural heritage used?
6. In what ways could it be used differently?
7. What do you think is one more thing I should ask in the next workshop?
8. When I write up my report of this session, what should I pay particular attention to?

Appendix L Research Study Abstract

ROYAL PRINCE ALFRED HOSPITAL
A tradition of excellence since 1882

Research Abstract

Cultural heritage can be as old as the Pyramids of Giza, or as young as the Sydney Opera House; as magnificent as Michelangelo's David, or as simple as the office chair Abraham Lincoln sat on. Put simply, cultural heritage consists of all the objects around us that have over time become important to us, either unwittingly, or as a result of deliberate selection processes. We value them in some way. There are no rules governing what can become cultural heritage but the object/s must encompass creativity and expressions as developed by us. These may be artistic in nature, important engineering designs or objects that convey important social and historical information.

There is an increasing appreciation in the value of our cultural heritage. It reflects our common identities and culture. It also unites us with our foundation stories and provides a solid base from which our society grows and develops. But cultural heritage is more than the many magnificent objects of our global social history: it also exists at a smaller organisational level. Many organisations have cultural heritage that has been collected, stored and protected through time. Collections occur for a variety of reasons. They can be through deliberate actions, incidental to other activities, and even accidental in that items no longer needed were stored instead of discarded. In many examples organisational collections are displayed in cabinets or housed in small museums. Dyson, the English home appliance manufacturer, showcases its vacuum cleaners in a large display case at the entrance to its building. The 1882 built Royal Prince Alfred Hospital (RPA) in Sydney, Australia, showcases its cultural heritage in a small museum, and around the grounds and buildings of the hospital. Both organisations see value in their heritage and so choose to display it.

Organisations such as these protect and showcase their cultural heritage in much the same way as do museums and galleries. But unlike museums and galleries it's not their core business, and so collection and preservation require a different level of support and set of organisational behaviours. It also requires an understanding from an organisational perspective as to why these objects are of "value", who they are valuable for, and therefore why they are significant enough to be determined cultural heritage.

There are a number of audiences who engage in an organisation's cultural heritage – staff, industry and community. It is for this reason that organisations frame values in the way they do – for example, brand and image, staff morale and culture, legacy and organisational heritage, staff retention and corporate social responsibility. In identifying this framework, a larger question emerges - what value does organisational cultural heritage provide to an organisation? Organisational members at RPA and Dyson engage daily with their heritage. What are the outcomes of this engagement?

The collection and preservation of organisational cultural heritage is rarely explored and poorly understood. I propose to investigate perceptions of value surrounding cultural heritage at Royal Prince Alfred Hospital. I hope to gain an understanding as to the value cultural heritage provides to the organisation. The results of my research may then be utilised by management to assist in the administration of collections and built heritage and be further developed for operational and strategic initiatives. They may also be utilised by other organisations in different sectors to better assist in the management of their organisational cultural heritage.

Appendix M Sydney Local Health District Ethics Approval

Address for all correspondence
Research ETHICS AND GOVERNANCE Office
Royal Prince Alfred Hospital
CAMPERDOWN NSW 2050
TELEPHONE: (02) 9515 6766
EMAIL: SLHD-RPAEthics@health.nsw.gov.au

NSW GOVERNMENT Health
Sydney
Local Health District

2 August 2019

This letter constitutes ethical approval only. You must NOT commence this research project at ANY site until you have submitted a Site Specific Assessment Form to the Research Governance Officer and received separate authorisation from the Chief Executive or delegate of that site.

Dear Dr Andrews,

Re: X19-0119 & 2019/ETH08672 - Framing and Valuing Cultural Heritage at Royal Prince Alfred Hospital

The Executive of the Ethics Review Committee, at its meeting of 2 August 2019 considered your correspondence of 31 July 2019. In accordance with the decision made by the Ethics Review Committee, at its meeting of 10 July 2019, ethical approval is granted.

The proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research.*

This approval includes the following:

- HREA (Version 4, 29 July 2019)
- Study Protocol (Version 3, 30 July 2019)
- Participant Information sheet (Version 3, 29 July 2019)
- Participant Consent Form (Version 3, 29 July 2019)
- Interview Outline and Questions (Version 3, 29 July 2019)
- Focus Group Outline and Questions (Version 3, 29 July 2019)
- Focus Group Interview Advertising (Version 3, 29 July 2019)

You are asked to note the following:

On the basis of this ethics approval, authorisation may be sought to conduct this study within any NSW/QLD/VIC/SA/WA/ACT public health organisation and/or within any private organisation which has entered into an appropriate memorandum of understanding with the Sydney Local Health District, Sydney Local Health Network or the Sydney South West Area Health Service.

The Committee noted that authorisation will be sought to conduct the study at the following sites:

- Royal Prince Alfred Hospital

- This approval is valid for **five** years, and the Committee requires that you furnish it with annual reports on the study's progress beginning in **July 2020.** If recruitment is ongoing at the conclusion of the four year approval period, a full re-submission will be required. Ethics approval will continue during the re-approval process.

- This human research ethics committee (HREC) has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review and is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.

- You must immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.

- You must notify the HREC of proposed changes to the research protocol or conduct of the research in the specified format.

- You must notify the HREC and other participating sites, giving reasons, if the project is discontinued at a site before the expected date of completion.

- If you or any of your co-investigators are University of Sydney employees or have a conjoint appointment, you are responsible for informing the University's Risk Management Office of this approval, so that you can be appropriately indemnified.

- Where appropriate, the Committee recommends that you consult with your Medical Defence Union to ensure that you are adequately covered for the purposes of conducting this study.

Should you have any queries about the Committee's consideration of your project, please contact me. The Committee's Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Sydney Local Health District website.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

The Ethics Review Committee wishes you every success in your research.

Yours sincerely,

Production Note:
Signature removed prior to publication.

Patricia Plenge
Executive Officer
Ethics Review Committee (RPAH Zone)
HERC\EXCOR\19-08

Appendix N University of Technology, Sydney Ethics Approval

Thursday, January 28, 2021 at 7:29:11 PM Australian Eastern Daylight Time

Subject: Your ethics application has been approved as low risk - ETH19-4052
Date: Monday, 26 August 2019 at 10:56:22 am Australian Eastern Standard Time
From: research.ethics@uts.edu.au
To: Research Ethics, Scott Andrews, Stephen Schweinsberg
CC: Adra Anthoney, Candice Gouck, Elizabeth Ng

Dear Applicant

[External Ratification: X19-0119 & 2019/ETH08672 - Framing and Valuing Cultural Heritage at Royal Prince Alfred Hospital has been approved by the Sydney Local Health District Research Ethics and Governance Office. HREC approval – X19-0119 & 2019/ETH08672 – July 2020 - July 2025]

Your local research office has reviewed your application titled, "Framing and Valuing Cultural Heritage at Royal Prince Alfred Hospital", and agreed that the application meets the requirements of the National Statement on Ethical Conduct In Human Research (2007). I am pleased to inform you that your external ethics approval has been ratified.

This ratification is subject to the standard conditions outlined in your original letter of approval. You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy (http://www.gsu.uts.edu.au/policies/research-management-policy.html).

Your approval number is UTS HREC REF NO. ETH19-4052.
You should consider this your official letter of approval. If you require a hardcopy please contact your local research office.

Approval will be for the period specified above and subject to the provision of evidence of continued support from the above-named Committee.

Please note that the ethical conduct of research is an on-going process. The National Statement on Ethical Conduct in Human Research (2007) requires us to obtain reports about the progress of the research, and in particular about any changes to the research which may have ethical implications. You will be contacted when it is time to complete your first report.

Please refer to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

To access this application, please follow the URLs below:
* if accessing within the UTS network: https://rm.uts.edu.au
* if accessing outside of UTS network: https://vpn.uts.edu.au , and click on " RM6 – Production" after logging in.

If you have any queries about this approval, or require any amendments to your approval in the future, please do not hesitate to contact your local research office or Research.Ethics@uts.edu.au
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REF: 12b

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