EPISTEMOLOGICAL FOUNDATIONS OF THE OBJET-À-PROJET AS A FACTOR IN THE DEFINITION OF PROJECTS: THE CASE OF PROJECT MANAGEMENT IN THE HEALTH SERVICES SECTOR

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Category: 12 RESEARCH METHODS AND RESEARCH PRACTICE >> 12_00 RESEARCH METHODS AND RESEARCH PRACTICE - SIG GENERAL TRACK

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ISBN 9782960219500.
ABSTRACT

We propose a different reading of the definition of a health services project. The polysemic nature of objet-à-projet, such as health, is not a concern in project management (PM). PMBoK has never included declensions of the epistemological postures of the objet-à-projet within the process of project definition. There exist several streams in PM as well as in medicine. In PM, we must incorporate Making Project Critical (MPC) to the Mainstream. In medicine, that which is naturalist/objectivist is in opposition to that which is normativist/interpretativist. The Mainstream, and that which is naturalist/objectivist, are both functionalist/positivist. The normativist/interpretativist is the source of a proposition which, when considered under MPC, underlines the polysemic nature of the objet-à-projet and the reflexive capacity of individuals to consider the various figures presented by a project according to the epistemological foundations of the objet-à-projet. We propose to integrate this analysis at the initiation process group of PMBoK.

Keywords: Project management, epistemology, health care
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Abstract

We propose a different reading of the definition of a health services project. The polysemic nature of *objet-à-projet*, such as health, is not a concern in project management (PM). PMBoK has never included declensions of the epistemological postures of the *objet-à-projet* within the process of project definition.

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We propose to integrate this analysis at the initiation process group of PMBoK.

**Keywords:** Project management, epistemology, Canguilhem, health care, *objet-à-projet*
Introduction

Continuous change within organizations forces them to adopt a form of management oriented towards projects. This fact is especially relevant to the extent that the control and monitoring model that was formerly prized is no longer sufficient for organizations to maintain competitive status. Already at the end of the 90s, Lester (Lester, Piore, & Malek, 1998, p. 88) reports that “The challenge facing the general manager under these circumstances begins to resemble the challenge that the manager of new-product development has always confronted.” Project Management, once the neglected aspect of Management, is now recognized as a process of knowledge creation where knowledge proceeding from different sources is assembled to create value added for the organization (Desouza & Evaristo, 2006; Pemsel & Wiewiora, 2013).

This tendency towards organizations centred on projects is motivated by the desire to generate more flexibility and openness in the marketplace. Projects, which are a method of structuring work in many organizations (Maylor, Brady, Cooke-Davies, & Hodgson, 2006; R Müller & Jugdev, 2012; Winch, Meunier, Head, & Russ, 2012), constitute one of the most important organizational changes (Winter, Smith, Morris, & Cicmil, 2006). We now use the term “projectification” to describe the organizations that have restructured their way of operating around a project-based approach (Godenhjelm, Lundin, & Sjöblom, 2015; Maylor et al., 2006; Midler, 1995; R. Müller, Zhai, Wang, & Shao, 2016).

Projectification even extends to one of the beacon institutions of western countries: health. In fact, western health systems are at the mercy of strong financial pressures (OECD, 2017).
Since project management is presented as an organizational performance lever (Crawford & Helm, 2009; PMI, 2017), it is hardly surprising that more and more organizations in the health sector see project management as the way to meet challenges posed by the evolving needs of populations for health services coupled with an accelerating rate of technological innovations.

In the sixth edition of its Guide to the Project Management Body of Knowledge (PMBoK), the Project Management Institute (PMI, 2017) identifies five project management groups: initiating, planning, executing, monitoring and controlling and closing. The initiating process group performed to define a new project object. For the PMI (2017), the initiation process group includes: development of a project charter and identification of the stakeholders. “Identify Stakeholders is the process of identifying project stakeholders regularly and analyzing and documenting relevant information regarding their interests, involvement, interdependencies, influence, and potential impact on project success” (PMI, 2017, section 2.2).

Regarding the project charter, it is developed using documentation on the strategic objectives targeted by the organization, the enterprise’s environmental factors and the organizational process assets. In any event, it is a matter of the PMI returning to theoretical foundations - or philosophical foundations to use the words of Konstantinou and Müller (2016) - underpinning the process of a project definition during the initiating process group. Such an intrinsic questioning is useless since one denies that the objet-à-projet can be conceived of differently according to the epistemological postures. There is therefore only one way of defining a project: that is to answer perfectly the needs of clients (i.e. institutions) and not of beneficiaries (i.e. patients), to be in harmony with only

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1 We will return to the notion of an objet-à-projet in the section on trends in project management.
the strategic orientation of organizations and to be totally in accordance with the environmental context.

The present paper follows in the footsteps of publications dealing with the philosophical foundations of the practice of project management (Bredillet, 2005, 2010; Ika & Bredillet, 2016; Lalonde, Bourgault, & Findeli, 2010). It concentrates on a subject passed over in the documentation on project management: epistemological foundations of the objet-à-projet as a key point in the definition of projects. We anchor our reflections towards the health sector since the very definition of health involves epistemological debates.

The article is organized into four sections. First, we propose to set the table by dealing with the polysemic character of the notion of health. The second part brings our attention to two major schools of thought in project management and to the social theories upon which they are based. In a third part, we briefly explore the philosophical approaches in medicine in order to delineate the two epistemological postures in medicine which will allow us to identify those that are taken into account by the literature on project management in the health sector. Finally, we propose an alternative model inspired by the work of Canguilhem anchored in Making Project Critical in order to rethink project management in the health sector.
I. Health: a Polysemic objet-à-projet

Most of the time in project management, the objet-à-projet is presumed to be “monosemic”: the different meanings that an objet-à-projet can have are not deemed to merit any particular attention when projects are being defined. However, in the health sector, “health” itself is subject to debates.

The definition of the World Health Organization (WHO) leads to many forms of questioning: “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (1946). This definition is somewhat similar to the Comtian vision of health in which medicine reveals itself to be less an abstract and specialized science than a “social” art because for Comte the veritable object of medicine is to heal society from its ills (Braunstein, 2009). For his part Georges Canguilhem defines illness as a behavior of negative value for a living individual in relation to polarized activities with his milieu (Canguilhem, 2015). Health is not that which is normal, but that which is normative, and living beings are able to surmount illness, stress, and modifications of their environment by creating new norms (Canguilhem 2015).

According to Lériche (1936) “health is life lived in the silence of the organs”. It can be defined also by others as being the absence of illness (Méthot, 2016) or according to French physiologist Claude Bernard, health is an objective concept that regards its origin as proceeding from pure determinism of biological phenomena (Giroux, 2009). Finally, Christopher Boorse (1975) stresses that physiology (or pathology) is the fundamental science of medicine. Indeed, Boorse uses his descriptive analysis as a starting point to arrive at a concept of health.
Considering the polysemy surrounding health, it is legitimate to reflect on the definition that is referred to when we define a program in a healthcare organization.

There are major stakes involved in the definition of health. First of all, it has epistemological importance for all those who are interested in envisioning care and its organization. However, the use of this knowledge is conditional upon the existence of a common understanding on the part of interested parties. But, much like spoil-sports we could question this interest in defining health, if in so doing we could expose another facet of the objet-à-projet that we wish to keep in the shadows. Secondly, in the strategic plan the definition of health is not of negligible importance. Indeed, together with the concept of illness, the definition of health has a normative function in our western society. For instance, health and illness serve to define the role of institutions like the departments of public health (Giroux, 2013). The ways in which we define health and illness also serve to circumscribe the pathological state in order to regulate legal expertise during trials. In addition, the definition is used by insurance companies who decide which services are insured or insurable. Finally, the definition of health can also play a role in the use of research funding and influence the medicalization of human life (Foucault, 2004; Méthot, 2016).

Obviously, some objet-à-projet such as health are polysemic. How does project management deal with this polysemy? To answer this question, let us review the different project management schools of thought.
II. Different streams of thought in project management and their ascendance over the definition of an objet-à-projet – relevance in terms of professional practice

Before reviewing the different streams of thought in project management, we should keep in mind the difference between what we consider to be an objet-à-projet and an objet-de-projet. The “a” in French indicates the temporal precedence in terms of the project. Whereas the “de” indicates the provenance, the belonging and the determination of the object. Thus, an objet-à-projet (health) is the raison d’être of the project, whereas an objet-de-projet is the result of the project (care). Taking into account the objet-à-projet as well as an objet-de-projet varies according to two schools of thought in project management, namely, Mainstream and Making Project Critical (see figure 1).

Figure 1. Temporal representation of the two conceptualizations of a project

The Mainstream, as some call it, (Hodgson & Cicmil, 2008), puts forward the themes of performance, of optimization, of success factors and the famous PM triangle: cost, time and quality. It is with the help of technical Gantt chart, the Pert, CPM and other such tools that the manager ensures efficient management of his project (Engwall, 2012; Gerald & Lechter, 2012; Olsen, 1971; Pinto & Slevin, 1988, 1988a). In the Mainstream the concepts of division of labour, task
specialization, and of hierarchal structure are the commanding concepts. We stress the performance of systems of production, efficiency of labour and optimal use of resources. The Mainstream borrows from classical schools of organizational theory and from the “One-Best-Way”. The guides to best practices (Body of Knowledge) and guidelines are used to standardize said practices by presuming that they attain their expected objectives. Projects are a process leading to the objet-de-projet. Consequently, the definition of a project follows a standard procedure seeking to respond to an extrinsic command (needs of clients, organizational strategies, socio-political, economic contexts etc.) without exploring the intrinsic philosophical stakes hidden behind the polysemic character of the objet-à-projet.

The organizations of the health sector in the industrial nations have adopted Mainstream as a framework to think about projects and their management: centralization of powers, a hierarchical and mechanical management of the processes leading to a net distinction between the work of the managers and those who execute the work (Dupuis & Farinas, 2010a, 2010b; Mintzberg, 2011). The Mainstream is in opposition to an approach which permits the development and deployment of specialized knowledge and of context related expert judgement, in other words, those competencies that belong to the various professions that are present in the organization of health care services (Dupuis & Farinas, 2010a). Among these professions, our attention is drawn to that of management. In project management, an analysis can be made on the professionalization of management as an institutionalization of control over occupations or on the establishment of links that exist between the knowledge of practitioners, the building of a professional identity and the maintenance of those links that belong to a well-grounded practice. These analyses will give birth to a second school of thought in project management, namely Making Project Critical.
In social sciences, the critical theory initially refers to the Frankfort school established by Horkheimer, Adorno and Marcuse, Benjamin and Fromm who constituted the first generation (Agger, 1991; Alvesson & Deetz, 2000). The second generation of the Frankfort school whose standard bearer is Jurgen Habermas returns to its initial objectives which are to conceive a society which not only has a knowledge of itself, but which also attempts to have a self-reflexivity (May & Perry, 2017). Its objectives are to shed light on the consciousness of capitalist exploitation and bureaucratic domination as well as to create a generalized need for freedom among the people, and a demand, a desire, and a need for a better world. Consequently, the critical school proposes to go beyond the classical vision of management (e.g. Taylorism, Fordism, and bureaucracy) and also beyond the application of good practices which are not guarantors of success or acceptability – as is the case in health services (Castonguay, 2012).

By drawing upon intellectual resources more critical than simply instrumental reason, positivistic, quantitative, and ‘technicist’ methodologies, Making Project Critical is interested in themes such as domination, ethics, moral responsibility and many others. Other disciplines influence this school of thought, namely philosophy, economics and politics. In parallel to Making Project Critical, the Scandinavian school bases its enterprise principally on the two following points: first, the project as a temporary organization (Lundin & Söderlund, 1995; Packendorff, 1995; Turner & Müller, 2003), and secondly, the dynamics of project practices (Hällgren, 2007; Lindkvist, 2006). Hence, Hällgren and Söderholm present the school of thought known as “Projects-as-practice” which treats the project as the sum of activities in which individuals are involved, and these activities are constantly renegotiated. This approach of ‘Projects-as-Practice’ is interested in how projects operates. It is interested in the inseparable relation that exists between the human being and his actions, and the forces and structures of society. The practitioner will be the one to give life to,
model and manage the project, and he will do so through context oriented actions (praxis) which are regulated by the framework derived from practice (norms, values, rules, policies that are generally accepted by the practitioner community).

For the critical school of thought, the project becomes a social space, a network, whose significance is constantly built and rebuilt through the praxis. It is an area of high stakes of power and of domination, stressed by the inequalities that arise and dissolve. The definition of an objet-à-projet (health) cannot be accomplished without making, consciously or not, the choice of an epistemological posture. This epistemological posture is accompanied by a whole series of postulates on reality and the categorization of social worlds which can be a potential source of discrimination for those who find themselves in said categories, with all the practices, judgements, inequities, and treatments that ensue.

The voice that is heard here is discordant in relation to the Mainstream. Defining an objet-à-projet (for example a treatment for a bacterial infection) does not consist in making available, key in hand, a simple output product (an antibiotic) that responds optimally to the needs of patients (healing) and to the organizational strategies (to render the patient functional) while being adapted to the environment (taking into account public or private coverage.) On the epistemological level, the knowledge borrowed from the definition of an objet-à-projet (health) is the result of social tensions, of economic stakes, of political pressures and of historical contexts. The objet-de-projet brings out these tensions. Philosophical reasoning that in no way retain the attention of PMI during the initiating process group can open or close social spaces. Let us take the example of Foucault regarding madness (Foucault, 1972). He has demonstrated that with the institutionalization of medicine (at l’Hôpital Général de Paris), madness was up to then accepted (a gift of God) and those
who displayed this condition were fully integrated in their community. As a consequence of medicine institutionalization (with the creation of l’Hôpital Général de Paris), madness became a pathology. Those who were so afflicted saw themselves refused access to their community and incarcerated in an asylum (at l’Hôpital Général de Paris).

Let us push our reflections a little further by dwelling more specifically this time upon philosophical approaches in medicine in order to delineate those approaches that are taken into account in project management literature in the health sector.

III. Approaches in the philosophy of medicine

“It is not because he falls ill that man dies; fundamentally, it is because he may die that man may fall ill.” Bichat

The purpose of this article – in the section thereafter- is not do an exhaustive presentation of everything that has been done on the philosophy of medicine\(^2\). Nor do we seek to express our views on the historical or academic contribution of philosophers like Nordenfelt, Boorse, Wakefield, Foucault, Canguilhem. We rather seek to show the difference between medicine’s two major epistemological approaches, and following this, to show what reflections can feed the work and research on project management in the realm of health.

In the last century, the production of knowledge in medicine was primarily based upon the positivistic philosophy of Auguste Comte (Braunstein, 2009) who, himself influenced by the works of Broussais, established the first foundations of a “physiological” medicine. These foundations can be summarized as follows: illness is an excess or lack in the excitation of various tissues above

\(^2\) Nor upon the great scientific discoveries such as the circulatory system, the respiratory system and the discovery of micro-organisms.
or below the degree that constitutes the normal functioning of the tissue. Thus, the pathological is identical to the normal, save for quantitative variations. Table 1 presents the different principles of each of the approaches in the philosophy of medicine that we are reviewing. We use the specific example of high blood pressure as our framework to underline the distinctive features of each of the approaches.

In stating “being able to determine physiological norms experimentally and to infer quantitatively what is pathological” (free translation) Bernard dissociates himself from the medical thinking of Broussais (Giroux, 2010, p. 20). According to Bernard, the physiology aimed at developing objective theories on health (see Table 1). The possibility of making medicine an objective science is questioned by Canguilhem who, with the introduction of his concepts of the “normal” and the “pathological” along with related concepts (health, illness, average, normality), places health and illness in their historical perspectives (Pénisson, 2008). The living is the creator of its own norms, the concept of illness applies to the subjective totality of the individual organism in relation with its milieu. Being sick, for Canguilhem (2015), is the whole of our rapport to life which changes, and it is never an objective element that one could isolate (see table 1 for an example).

At the opposite end Boorse (1975, 1977, 2014) puts forward that health and illness are two concepts which are mutually exclusive: health is habitually defined as the absence of illness (Giroux, 2009, page 39, Méthot, 2016, page 20). In order to develop a neutral theoretical concept, Boorse will place the physiology at the centre of medical science. Illness is nothing but the sub-optimal functioning for the species. He develops the bio statistic theory, which is a functionalist/positivist theory. This theory is based on the two principal concepts: the biological function and statistical normality. To these two concepts are added the characteristics of the species (animal). It is by being associated with a concept of biological function that the statistical normality adequately defines
medical normality. In other words, according to this concept, someone who is in good health is someone whose biological functioning corresponds to that of the majority of his species according to the group of reference - the age group and the gender - in which this organism is to be found (i.e. statistical normality) (Provencher, 2016). Organisms displaying a biological functioning that is below or above the norm (therefore different from the majority) are considered abnormal at a physiological level, therefore ill (see table 1 for an example).

The American philosopher Wakefield (Wakefield, 1992) takes a more nuanced position than Boorse when he proposes the “Harmful Distinction Analysis” or HDA. HDA puts forward the idea that a pathological state must not only involve a prejudice to the individual, but must also include a biological dysfunction. Recognizing that a biological dysfunction is necessary but not sufficient to conclude the presence of a pathological state, Wakefield maintains that the harm or prejudice caused to the individual will be determinant in the demarcation between a state of health and a state of illness. Given this, values play an undeniable role in this process (see table 1).

We end this rapid overview of the approaches in the philosophy of medicine by examining the “holistic” theory of the Swedish philosopher Nordenfelt (2007). This theory recognizes a relation between the concept of health and the capacity to attain a certain number of vital objectives, for which this theory seeks to identify the minimal conditions generally shared between individuals (Méthot, 2016).
Table 1. Different representations of high blood pressure according to the philosophical approaches used

<table>
<thead>
<tr>
<th>Author</th>
<th>Principle</th>
<th>Representation of high blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broussais</td>
<td>Over excitement of tissues</td>
<td>Excessive stimulation of nervous tissue causing an increase in blood pressure</td>
</tr>
<tr>
<td>Bernard</td>
<td>Pressure on the walls blood vessels</td>
<td>Invasive measures to take a measure of blood pressure, blood volume etc., in order to determine its objective values</td>
</tr>
<tr>
<td>Canguilhem</td>
<td>Meeting between a patient and a doctor</td>
<td>The individual feels ill and consults the doctor so they can together agree on a treatment</td>
</tr>
<tr>
<td>Boorse</td>
<td>Statistical measurement</td>
<td>Individual is declared to have high blood pressure (even without apparent symptoms) because his results exceed those of the same age group and the same gender in the population</td>
</tr>
<tr>
<td>Wakefield</td>
<td>Prejudice and dysfunctionality</td>
<td>The diagnostic of high blood pressure (i.e. the gap in the population studied) pushes life insurance up</td>
</tr>
<tr>
<td>Nordenfelt</td>
<td>Minimal conditions preventing the attainment of vital objectives</td>
<td>High blood pressure brings about incapacity and suffering because, for example, the cost of medication cuts into family revenues</td>
</tr>
</tbody>
</table>

From this short review of the different philosophical approaches to medicine, we can identify two epistemological postures regarding health and illness. First, there are the naturalists, who could also be called objectivists, who affirm that health and illness are concepts capable of being described by the natural sciences, much like other facts of nature, and moreover, that they are concepts that are independent of moral and social values. Boorse’s bio-statistical theory still today constitutes the dominant approach of this group. Then, there are the normativists or interpretativists for whom the concepts of health and illness cannot be reduced to natural facts of this kind. These are seen as undesirable states that demand action, and that we should seek to avoid. In other words,
“these concepts reflect a certain number of cultural and social values which have evolved in the course of time, and not an objective, underlying, biological or pathological reality.” (free translation, Méthot, 2016, p.18). It follows that “the border between the normal and the pathological is imprecise” and different for each of us “but, it is perfectly precise for a single, same individual considered successively” (free translation, Canguilhem, 2015, p. 156). Canguilhem characterizes health by the “possibility of surpassing the norm that defines momentary normality, the possibility of tolerating infractions to the habitual norm, and to institute new norms for new situations. One remains normal, surrounded by a system of specific requirements, with a single kidney”. (free translation, Canguilhem, 2015, p. 171). He defines illness as “a reduction in the margin of infidelities of the milieu”. (free translation, Canguilhem, 2015, p. 132).

To follow up the presentation of the different philosophical approaches in medicine, let us now look at those that are taken into account by project management literature in the health sector.

**Epistemological postures on health and project management literature in the health sector**

A survey of the literature was undertaken to see if the “naturalist/objectivist” and “normativist/interpretativist” were recognized or discussed in management or in project management in the health sector. This survey was inspired by Ridley (2012). We did a literature review of publications in the ABI/Inform Global data base. We searched for the words “health” and “project management” in the subject section to find peer-reviewed articles between January 1990 and April 2017. A total of 243 articles were identified. Of this number, we excluded those dealing with the domains of “health-care industries” and “occupational health”. The contents of
the remaining 186 articles were then surveyed using keywords that are wildly recognized as identifying the subject being dealt with (Hamilton, 2010; Khushf, 2007; Lemoine, 2013; Sholl, 2015): “constructivism”, “naturalism”, “normativism”, “objectivism”, “interpretativism”. In all seven articles were retained following the second screening.

A reading of these articles allowed us to note that three articles do not deal with project management per se, namely those of Prosser, Thomas & Darling-Fisher (2007), Dickson, Price, Maclaren & Stein (2004) and McKie & Richardson (2011). As for the four remaining articles, the key words that were searched did not relate to the concept of health and illness but rather to problems arising from the reform of health systems (Whitehead, 2005) or approaches to management (Klecun & Cornford, 2005; Peltokorpi, Alho, & Kujala, 2007; Winthereik, 2008).

Our literature review underlines the fact that epistemological postures are absent in the project management literature of the health sector. The results of this review can potentially be explained by the fact that PMI (a collective player pivotal to the Mainstream) has never taken into account declensions of epistemological postures of an objet-à-projet (such as health) when projects are being defined. Consequently, this reflective exercise of returning to philosophical foundations does not seem to be innate to the project management authors in the health sector.

Until now, health care projects have been conceived using the road of the Mainstream. Now, what would happen if we used the road of Making Project Critical?
IV. A new normativist/interpretativist model (a new insight for project management in health sector)

Earlier we distinguished two philosophical approaches in medicine, naturalism/objectivism and normativist/interpretativist. The former has certain acquaintances with the Mainstream since both are functionalist/positivist. The latter puts the accent on economic performance, rationalization, and on Fordist and mechanistic characteristics and the erection of vertical structures within organizations at the expense of individuals. Boorse’s biostatistics (the naturalism/objectivist model) attributes no importance to relations with the patient, and even, if such a relationship takes place, it does not in any way contribute to the production of knowledge. Knowledge is here seen as an institutional matter and not a relational matter. Illness is thought of in terms of the biological function of sick organs, and not in terms of individuals or interpretations. It objectifies itself through numeric designations of performance (a value for high blood pressure, for blood cholesterol), cuts itself up into specialties and processes, and divides itself into services, and this quantification has social consequences. Chauvenet (1973, p. 61) refers to an “industrialization” of work in the hospital milieu. “where the medical act is broken down into a series of complementary interventions, carried out by specialized medical resources within technically differentiated units” (free translation, Chauvenet, 1973, p. 61). The economic aspect seems to assume a higher importance than the social aspect of medical practice. The very progress of medicine might cause us to fall back into the medicine of ‘slaves’; impersonal, mute, anonymous, for reasons that originate from the organization: breaking down the sick into individual organs, with a need to fragment illness, and the importance of specialized medicine. The Plato’s problem (we are here referring to the medicine of slaves and of free men dealt with in Laws IV) has not diminished, but has rather increased in the technocratic era, – a process of ‘technicalisation’ of the world. The
problem no longer implies a distinction between free doctors or slave doctors, but rather between personal and individual doctors or impersonal and collective doctors.

The first column on Table 2 offers a synthesis of how the Mainstream in project management and the naturalist/objectivist approach in medicine have cross relations.
Table 2. Cross-relations between project management streams of thought and the philosophical approaches in medicine.

<table>
<thead>
<tr>
<th>Philosophical approaches to medicine</th>
<th>Streams of thought in project management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naturalist/Objectivist (Boorse’s bio statistics)</td>
<td>Mainstream</td>
</tr>
<tr>
<td>Project-as-Process (Definition of the project centred on the needs of clients, strategies and environmental factors)</td>
<td>Medicine: Segmentation, specialization, pathology, physiology, absence of the patient, normality, return to the pre-illness state (cure)</td>
</tr>
<tr>
<td>Normativist/Interpretivist (Canguilhem)</td>
<td>Medicine: Holism, totally subjective/interpretativist towards the organism, singular doctor/patient dialogue, Medicine of free men, normativity, an art at the crossroads of many sciences, cure consists of attaining a new equilibrium.</td>
</tr>
</tbody>
</table>
Conversely, Canguilhem, the bearer of a critical vision on healthcare, becomes an opponent of naturalism/objectivism whose rise is to the detriment of a “Holistic” vision. For it is a mistake here to think that we can reduce the experience of illness to an object of science without receiving interpretativist input from individuals (practitioners, clients and beneficiaries of the project); this is where MPC and Canguilhem converge (see column Making Project Critical, table 2).

A Canguilhem vision of the project

Instead of perceiving the ill person or the patient as a “wild card” who must at any price be unable to interfere, Canguilhem’s style of project management welcomes the patient with open arms as a source of knowledge indispensable to the definition of the objet-de-projet (care). One recognizes that in the “Mainstream” the patient is considered to be a distraction without any significant knowledge.

“It is therefore in the name of sovereign knowledge over the human body that medicine has insured its control on the life of individuals, each one of them being a potentially sick person susceptible of being alienated in the totality of his own being, which ceases to belong to him when he gets sick.” (Free translation, Guillec, 1990 pg. 369).

On the other hand, Canguilhem, without saying it so explicitly in his writings, encourages the reflectiveness of the patient or sick person, the beneficiary, in his appreciation of “his health” and of “his care”. This reflective knowledge (Antonacopoulou & Tsoukas, 2002; Cicmil, 2006) should
be encouraged and should enrich the culture of project management with a view to improving the
definition of the *objet-de-projet* (care).

While the reflexive practitioner may be an element of the critical discourse who does not pose
much of a problem to the structural integrity of the dominant hierarchy, the reflexive patient
(beneficiary) is another matter. He is not part of the modalities with which institutional power
wants to deal. Organizational structures, whose centralization increases with each new reform,
cannot concern themselves with what the population thinks. This fact causes little concern because
organizations are possessors of knowledge and power, and know what needs to be done for the
well-being of patients. Therefore, in this naturalist/objectivist vision of the Mainstream, the *objet-
à-projet* (health) is univocal, and the *objet-de-projet* (care) as defined by the experts consists in
doing what is needed so that the sick organ and not the individual returns to normal functioning in
light of norms derived from population statistics in order to satisfy the needs of a client
(institutions).

Contrariwise, a Canguilhem project management begins with the patient’s (beneficiary’s) own
knowledge of his health. The reflexive patient is the motor who gives impulse to the praxis that is
the creation of his care. In this sense, we can think of mutual aid groups, such as the GEMs in
France or the club-houses first begun in New York in the 40s. These clubs, which were initially
formed by a spontaneous gathering of psychiatric patients, organized themselves into mutual aid
groups whose members are helped by a team of health professionals who they choose themselves.
Such mutual help groups, even though they follow a different logic concerning care, create
partnerships with psychiatric teams, and with associations of care users or of care users’ families
(Durand, 2009). Other kinds of groupings will, no doubt, be subject to a project. Medicine runs the
risk of creating an even greater demand on the health care system by constantly pushing the
inevitable further and further aside (Kleinman & Hanna, 2008). To break out of this situation, medicine will have to promote a practice based on the reflexive knowledge of practitioners as well as that of beneficiaries to get away from technicality and to return to the “singular dialogue”.

**Conclusion**

We have proposed making a distinction between the *objet-à-projet* (health) and the *objet-de-projet* (care) in the area of health project management, so as to propose a different reading of the definition of projects. First, we note that the polysemic character of health as the *objet-à-projet* does not seem to preoccupy the authors who publish on this subject because the PMI has never included a declension of epistemological postures of *objet-à-projet* such as health, when defining projects (the initiating process group).

After having examined the two major project management streams of thought, we have noticed that “Mainstream” is the prevailing school when it comes to the management of care and services systems, and also that “Mainstream” is the school with which the naturalist/objectivist approach in medicine has the most conceptual affinity. The second approach, the normativist/interpretativist, is the basis of a theoretical proposition which, when conjugated with Making Project Critical, returns the individual (practitioners, patients/beneficiaries and clients) to his reflexive role, as a creator of knowledge on the *objet-à-projet*, as well as to his role agency (practice-project), leading to a definition of the *objet-de-projet*.
One should not misunderstand our comments, for we are not dismissing with the back of our hand the initiation process group of PMI (2017). We are supporting the integration of a third component into the initiation process group (the first two components being: the developing project charter and identification of stakeholders). The objective of this new component is to describe the forms that an objet-de-projet can take according to the variations of the epistemological foundations of the objet-à-projet. In other words, understanding the importance of epistemology for the ontology of a project.
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