Paradox in the house

Accomplishing plurality, stability and routinized reflection in a hospital

Habilitation submission

by

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1 The improbability, the impermeability, and the change of pluralistic organizations

The deep-rooted tensions that are built into the pluralistic organization seem to make its mere ability to hang together something of a mystery (Kraatz & Block, 2008: 257)

Pluralistic organizations pose an intriguing puzzle: On the one hand, they appear improbable (Kraatz & Block, 2008). The multiple demands of their environment (Denis, Lamothe, & Langley, 2001; Jay, 2013), the diverse interests of relative autonomous actors (Jarzabkowski & Fenton, 2006), and the different perspectives (Glouberman & Mintzberg, 2001a, b) that are associated with a variety of knowledge-intensive work (Denis, Langley, & Rouleau, 2007b) and with ways of acting (Glouberman & Mintzberg, 2001a; Jay, 2013) are often incompatible or in tension with one another. While differentiation is necessary for advancing knowledge and expertise through specialization, it increasingly requires and inhibits the integration of pluralistic parts due to intransparency and contradictions (Neuberger, 2000). Kraatz & Block (2008: 257) calls it a "mystery" how a pluralistic organization accomplishes itself.

On the other hand, scholars observe that pluralistic organizations are impermeable to deliberate change attempts. Instead of nearly collapsing, they appear remarkably stable (Tucker & Edmondson, 2003; Weick & Sutcliffe, 2003). The literature on hospitals, for example, reports a variety of difficulties and failing initiatives to alter these organizations. The relative autonomy of internal actors associates with ambiguous power relations. Therefore it is difficult to lead without the consent of the led (Denis et al., 2001). The different perspectives of these actors foster misunderstanding and conflict (Iedema, Degeling, Braithwaite, & White, 2003) rather than enhancing a shared perspective when aiming to deliberately pursue an organization-wide initiative (Bate, 2000; Ericson, 2001). As a result, change initiatives can become corrupted and diluted (Lozeau, Langley, & Denis, 2002), or decisions can be continuously postponed for example (Denis, Dompierre, Langley, & Rouleau, 2011). There are also reported successes (Edmondson, Bohmer, & Pisano, 2001; Kellogg, 2011; Reay, Golden-Biddle, & Germann, 2006) that show that deliberately altering how a hospital operates often bears mixed results (McNulty & Ferlie, 2004).

Taken together, pluralistic organizations appear both improbable and stable. This puzzle points to three research interests that guide the following text and the empirical investigations: First, I explore the plurality of these organizations that suggests their improbability. Second, I investigate how a pluralistic organization accomplishes stability. Third, I analyze a deliberate attempt to handle the opposing organizational understandings ingrained within a single department by means of collective reflection.

Exploring these research interests is important for hospitals and different pluralistic settings and can also be inspirational for other organizations (Denis et al., 2007b). In most developed economies, the healthcare sector is among the largest industries, and hospitals are key institutions therein (Widmer, 2011). They offer an existential service to the public while incurring a large portion of the resources. At the same time, hospitals face demands for further developing their organization and management. Given the mixed results of such initiatives, there is a need to advance our understanding of these organizations and their management. Such insights may also contribute to other pluralistic settings and organizations because our societies increasingly rely on the knowledge-intensive work of experts (Handy, 1994) with which organizations in general become increasingly pluralistic (Denis et al., 2007b; Jarzabkowski & Fenton, 2006).

The remainder of this introduction provides an overview on the coming chapters. The following section contains the three research questions for the paradox lens that are addressed by drawing on routine dynamics literature (see chapter 2). The third section introduces the analytic framework and the research design (see chapter 3), followed by three sections with an overview on the results and contributions of the three empirical investigations. The first section summarizes that the hospital studied is founded on the paradox of differentiation and integration (chapter 4). The second section demonstrates that differentiation and integration relate through the coordinating routine practitioners called “bilateralism” (chapter 5). The third section introduces the finding of routinizing reflection as both a means and outcome to handle the paradox of opposing views on organization (chapter 6). The empirical insights of these three chapters contribute mainly to the paradox literature, but also to routine dynamics (section 1.7). Before concluding the introduction, section 1.8 points out the relevance of this research.

1.1 Three questions for the paradox lens

Chapter 2 offers a review of the paradox literature which provides a promising approach to explore the three research interests on pluralistic organizations. The Paradox lens assumes that paradoxes are integral to organizations (Lewis, 2000; Putnam, 1986; Quinn & Cameron, 1988; Smith & Lewis, 2011). Paradox comes into play because organizations draw distinctions that form different subsystems (Ford & Backoff, 1988). These subsystems are independent and interdependent. They are sometimes incompatible, but necessary together to achieve overall success (Jarzabkowski, Lê, & van de Ven, 2013; Lewis & Smith, 2014).

Paradoxes become salient once actors experience plurality, when an organization conducts change initiatives or faces resource restrictions (Lewis & Smith, 2014). Under these circumstances, the independence and interdependence of different subsystems like departments, clinics, or professions come to the fore (Ford & Backoff, 1988; Luescher, Lewis, & Ingram, 2006; Luhmann, 2000; Rüegg-Stürm, Schedler, & Schumacher, 2015). Otherwise, paradoxes are considered to remain latent, i.e., they lie dormant and unobserved by organizational members.

Paradoxes invite actors to handle them and thereby address rationally unsolvable tasks (Beech, Burns, Caestecker, MacIntosh, & MacLean, 2004). They prompt us to adopt paradoxical thinking (Westenholz, 1993), devise workable solutions (Luescher & Lewis, 2008), or practice consistently inconsistent decision-making (Smith, 2014) in order to relate the opposing poles or subsystems in a "both-and" way that leaves them intact (Clegg, Vieira da Cunha, & Pina e Cunha, 2002).

Within the paradox literature, there are three open issues that correspond with my research interests on pluralistic organizations:

- First, studies on paradoxes often address the tensions between the poles of a paradox but seldom *explore these poles* in context-specific detail to demonstrate how a paradox is accomplished within organizations. Understanding the poles informs possibilities to act on paradoxical tensions. These tensions result from the incompatibility when the poles adjoin, while they appear coherent by themselves (Lewis, 2000). This open issue resonates with the research interest on exploring an organization's plurality. The different autonomous knowledge-intensive actors

represent the organization's subsystems that compose a pluralistic organization, for example, a hospital.

- Second, studies rarely attend to the *prior paradox solution* that a proposed new one aims to alter. The prior solution expresses the locally accomplished relationship between the poles of a paradox (Clegg et al., 2002). Because paradoxes become salient occasionally (Smith, 2014), the relationship between them leaves the paradox latent. Therefore, paradox latency is essential for the paradox lens. But current literature does not investigate paradox latency in detail and thereby overlooks how an organization can achieve stability before a paradox becomes salient. Focusing on paradox latency by exploring the relation between the opposing poles helps to illuminate how the autonomous but often incompatible subsystems achieve a pluralistic organization's stability.

- Third, the paradox lens currently notes the *difficulties to embed paradox solutions* within an organization (Jarzabkowski et al., 2013; Jay, 2013; Luescher & Lewis, 2008; Smith, 2014). The difficulties of embedding paradox solutions are associated in part with the previous open issues of incorporating the paradox poles and their enacted relation in context-specific detail. In addition, the difficulties arise from separating between those organizational members who develop a proposed solution and those who are to implement it. This open issue of embedding paradox solutions associates with the empirical research interest of how to conduct a deliberate change initiative within a pluralistic organization.

The empirical research interests and the open issues prompt three *research questions*:

1. How does a pluralistic organization accomplish paradox?

2. How does a pluralistic organization handle paradox and achieve latency?

3. How can paradox solutions[1] become embedded in a pluralistic organization?

These research questions draw on a *process perspective* (Hernes, 2008; Langley & Tsoukas, 2010). A process perspective associates with pluralistic organizations that are characterized by incoherence, incompatibility, interdependence, and tensions (Denis et

[1] In this text and in line with the literature, I will use the term "solution" to paradoxes despite its misleading meaning. More precisely is to speak of "unfolding" a paradox (Luhmann, 2000) while reserving "solution" to situations that are solvable.

al., 2011; Denis et al., 2001; Denis et al., 2007b; Jarzabkowski & Fenton, 2006; Jay, 2013; Lozeau et al., 2002; Rerup & Feldman, 2011). In comparison, entitative theories of organization and management tend to assume away plurality (Abbott, 1988; Hernes & Weik, 2007; Jarzabkowski & Fenton, 2006; Kieser, 2002; von Foerster, 1994). This research tradition tends to pre-suppose coherence, sameness, and linearity. In comparison, the process perspective builds on a constructionist epistemology (Gergen, 2002) with a world constantly in the making (Tsoukas & Chia, 2002). Therefore the process perspective provides my general research basis.

As part of process research, I draw on *routine dynamics* to address the three research questions. Studies on routine dynamics prompt us to attend to organizations as active accomplishments (Feldman, 2000). This research highlights the inherent dynamic in everyday activities of organizations and shows that stability is not given but continuously accomplished (Feldman, 2000; Zbaracki & Bergen, 2010), emerging over time (Bresman, 2013; Rerup & Feldman, 2011), embedded in a specific context (Howard-Grenville, 2005), entangled with other routines (Turner & Rindova, 2012), while the understandings of a particular routine are multiple (Cohen, 2007; Dionysiou & Tsoukas, 2013; Zbaracki & Bergen, 2010) and associate with the organizational understandings of its members (Feldman, 2003; Rerup & Feldman, 2011).

Routine dynamics and the paradox lens relate conceptually because they share the *assumption of self-referentiality*. As something referring to itself in general (Ortmann, 2004; von Foerster, 1984), the process literature defines self-referentiality as “mutual constitution” (Feldman & Orlikowski, 2011) or “duality” (Farjoun, 2010; Orlikowski, 1996). In a duality, two components relate in a way that they appear simultaneously “contradictory and complementary” (Farjoun, 2010: 203). In addition, “[r]elations of mutual constitution produce the very system of which they are part” (Feldman & Orlikowski, 2011:1242). In this respect, mutual constitution resonates with the concept of autopoiesis of second-order cybernetics that depicts systems as self-referential (Maturana & Varela, 1980). Self-referentiality broadens the one-directional relationship of thinking in cause-and-effect towards one in which both these components bring forth each other (Kaufman, 1996). In my research, self-referentiality serves as a mechanism or sensitizing device to explain process patterns (Langley, 2009; Langley & Tsoukas, 2010).

1.2 The analytic framework and the research design

While self-referentiality offers a sensitizing device, *the analytic framework* proposed in chapter 3 guides the empirical research. The framework consists of paradox and meaning structure, the latter of which is composed of organizational understanding and routines.

Paradoxes contain opposing but interrelated and persisting elements, poles, or organizational subsystems (Smith & Lewis, 2011). In a pluralistic setting, a paradox results from the different subsystems or worlds that manifest in the professions and disciplines of a hospital, for example (Glouberman & Mintzberg, 2001a; Luescher et al., 2006; Luhmann, 2000). I conceptualize these subsystems as meaning structures (Hernes, 2014). As meaning structures, subsystems contain the organizational understanding and the associating routine and non-routine actions and communications. Organizational understandings provide the members with ideas of 'how things are around here in this organization'. The organizational understanding guides the members' practice and thereby enacts the organizational understanding (Feldman, 2003). In this way, "actors operate within and upon meaning structures" (Hernes, 2014: 111). The actors' (non-) routine practice and the organizational understanding relate self-referentially. They form a duality (Farjoun, 2010; Feldman, 2003; Rerup & Feldman, 2011).

The analytic framework guides the empirical research. Situated in a single hospital, the case study research (Yin, 1994) consists of different change initiatives. In our longitudinal and direct research (Mintzberg, 1979), we adopted the role of empathetic non-participant observers (Langley, 2009) and spent five years in the field. Two-person teams observed the integration of the two hospitals "Reho" and "Laho" that formed a hospital region; the introduction of a new surgical regime; the implementation of a new employment law; and the establishment of a center for palliative care. These case studies provide in-depth knowledge on different disciplines and professions[2] across all levels of hierarchy and in particular on nursing, inner medicine, and surgery. The following text draws on these data with a specific concern of the hospital integration.

Guided by a contextualist framework (Pettigrew, Woodman, & Cameron, 2001), the empirical research draws on qualitative data sources. The data analysis aims to elaborate on theories (Lee, Mitchell, & Sablynski, 1999) within the paradox lens and rests on

[2] The term "disciplines" refers to the different specializations within a profession mainly within the medicines like surgery, inner medicine, or cardiology. In comparison, "profession" refers to the spheres of nursing, medicines and administration.

different means to theorize from process data (Langley, 1999) resulting in thick contextual descriptions of single case studies (Pettigrew, 1990). Over the past eight years, the current insights emerged from varying cycles that iterate between these case studies, the original data, and other literature. As a result, I selected the paradox and routine dynamics literature and specified the background perspective of social systems theory (Luhmann, 2000). This specification is on self-referentiality as rooted in second-order cybernetics (Maturana & Varela, 1980; von Foerster, 1984, 1994).

Overall, the research process provides specific and accurate results with moderate generalizability due to the focus on process rather than outcome (Langley, 1999; Stiles et al., 2015). These results in the chapters 4-6 are introduced in the following sections.

1.3 The paradox of differentiation and integration

First, and regarding the improbability of pluralistic organizations, the empirical results of chapter 4 demonstrate that the researched pluralistic organization is based on a paradox. The paradox contains the poles of “integration” and “differentiation” (Andriopoulos & Lewis, 2009; Glouberman & Mintzberg, 2001a, b; Jarzabkowski et al., 2013; Lawrence & Lorsch, 1967). It emerges from not only different interests and understandings as existing literature suggests. But also, the paradox emerges from the heterogeneous ways of acting by which the organizational members operate within and upon their meaning structures. I generate this insight, first, by comparing different professions and disciplines of surgery, inner medicine, and nursing across the accompanied initiatives. Second, my results demonstrate the members’ awareness of integration as they criticize the so-called “garden thinking” and emphasize the importance of jointly handling organization-wide issues.

These insights build on and contribute mainly to the emerging process perspective within the paradox lens (Abdallah, Denis, & Langley, 2011; Andriopoulos & Lewis, 2009; Clegg et al., 2002; Jarzabkowski et al., 2013; Jay, 2013; Smith, 2014), but they also contribute to routine dynamics (Parmigiani & Howard-Grenville, 2011).

Regarding the paradox lens, this literature states that paradox is integral to pluralistic settings. The research of chapter 4 contains three contributions:

- First, I depict empirically *the ways of acting* (Jay, 2013: 140) of who becomes involved on what issues, how, and when. The ways of acting contribute to a processual view within the paradox lens by adding *how* the diverse interests and understandings are enacted; thus, they complement the insight *that* those interests and understandings characterize plurality.

- Second, the comparison between the meaning structures illuminates *how the different clinics or departments reproduce themselves endogenously* and accomplish their own stability. Thereby, this study shows how different subsystems reproduce themselves and appear logical within themselves (Lewis, 2000). This actively accomplished stability within meaning structures helps to explain how the differentiation persists within the organization, substantiating the assumption that paradoxes are integral to organizations (Lewis & Smith, 2014; Smith & Lewis, 2011).

- Third, and with rising organization-wide issues, it becomes increasingly important to integrate the different subsystems. Issues like a hospital-wide strategy, a revision of the controlling system, or the integration of another hospital mark the pole of integration. Integration and differentiation form the paradox that is fundamental for the studied pluralistic organization (Clegg et al., 2002; Jarzabkowski et al., 2013; Lawrence & Lorsch, 1967). Differentiating an organization into different subsystems creates the need to integrate them (Ford & Backoff, 1988). Focusing on this paradox invites to reconsider their positioning on the individual, group, and organizational levels that the literature proposes. Alternative to different levels, the identified paradoxes can be related to or seen as expressions of the founding paradox.

1.4 The coordinating routine of “bilateralism”

The second part of the investigation (chapter 5) elaborates on how the different subsystems relate routinely. The empirical results on the organization-wide issue of integrating Reho into Laho emphasize an informal coordinating routine the practitioners call “bilateralism”. Enacting this routine, the involved actors achieve commitments to act across different meaning structures. “Bilateralism” enables the organization to relate both poles of the foundational paradox and leaves them intact. At the same time

"bilateralism" accomplishes paradox latency within the executive board. Potential or actual conflicts transfer from the executive board to private conversations, to projects, or are left unresolved for the time being. By these means, the coordinating routine reproduces the foundational paradox. Both form a duality (Farjoun, 2010) The coordinating routine and the foundational paradox relate like a self-fulfilling prophecy (Weick, 1995) or bootstrap (Barnes, 1983) that helps to accomplish the stability of this pluralistic organization. These empirical results suggest three contributions to the paradox lens:

- First, the identified *coordinating routine relates the opposing poles* in a both-and way that emerges from local and situative practice and leaves the opposing poles intact (Clegg et al., 2002). The coordinating routine expresses the relation between the subsystems before actors envision deliberate alternatives. The coordinating routine points to the prior solution of the paradox that the literature tends to omit (Beech et al., 2004; Lewis, 2000; Luescher & Lewis, 2008).

- Second, the relation between the poles involves *the accomplishment of paradox latency*. While most works take paradox latency as an initial assumption, my research embarks on investigating how it works. In my case, latency occurs in collective settings, while the paradox is salient to individual members. Thereby, my study provides empirical evidence to the assumption of paradox latency that is essential for the paradox lens.

- Third, I argue that *the paradox and the coordinating routine form a duality* in that they mutually draw on each other. This duality helps to explain how a pluralistic organization achieves stability. The duality of the paradox and the coordinating routine specifies the pervasive yin and yang metaphor often used in paradox literature (Lewis, 2000; Smith & Lewis, 2011).

1.5 Routinizing reflection to embed paradox solutions

The third empirical chapter 6 investigates a deliberate attempt at organizational change. The case of integrating Reho's nursing department into that of Laho concerns the initial contradiction of the two departments' meaning structures and its handling over time. In this case, establishing reflective routines is a central means to relate both meaning

structures and to shift the organization from the enacted towards the proposed one. Reflective routines are repetitive patterns of observing other routines, like those for patient treatment or administrative tasks. In addition, reflective routines provide the means to also observe the unfolding attempt to change (see section 2.2.3.3, p. 47ff.).

The empirical case gives rise to a process model of routinizing reflection. This model displays how opposing meaning structures relate over time to weave a proposed meaning structure into an enacted one (see Langley & Denis, 2006). Routinizing reflection reaches out from individual observing to the entire department and encompasses a differentiated array of topics in different temporal rhythms. Therefore, routinizing reflection is both a means and an outcome of altering the studied nursing department.

The model of routinizing reflection addresses the current open issue within the paradox literature on how to embed solutions to a paradox and offers four contributions (Jarzabkowski et al., 2013; Jay, 2013; Luescher & Lewis, 2008; Smith, 2014):

- First, it shows *the pattern of emerging reflective routines* that advances insights on individual and group reflection when handling paradoxes (Jay, 2013; Luescher & Lewis, 2008; Smith, 2014).

- Second, the model of routinizing reflection displays *the importance of resonating with the opposing poles of the proposed and the enacted meaning structure*. This double resonance enables to weave the former into the latter, not only in terms of their content but also in terms of how the reflective routines are conducted (Abdallah et al., 2011; Andriopoulos & Lewis, 2009; Clegg et al., 2002; Jay, 2013; Smith, 2014). Thus, relating both poles of the paradox includes the “ways of acting” (Jay, 2013: 140) that helps to shift organizational understandings.

- Third, *routinizing reflection overcomes the separation* between the senior leaders who envision the solution and their subordinates who are expected to enact it (Abdallah et al., 2011; Ford & Backoff, 1988; Luescher & Lewis, 2008; Smith, 2014; Smith & Lewis, 2011). The inclusion of organizational members to reflect on their daily work and on the envisioned changes addresses the risk of misunderstanding the proposed solution (Barrett, Thomas, & Hocevar, 1995; Bartunek & Moch, 1994; Westenholz, 1993).

- Fourth, *designing and implementing paradox solutions occurs simultaneously* within routinizing reflection. The literature implies that solutions are envisioned before they are implemented (Jarzabkowski et al., 2013; Luescher & Lewis, 2008). In comparison, routinizing reflection resonates with improvisation, which scholars understand as planning while acting (Clegg et al., 2002; Orlikowski, 1996; Weick, 1995), or envisioning and enacting paradox solutions, respectively.

1.6 Further contributions offered to routine dynamics

Besides contributing to the paradox lens, the insights of chapters 4 to 6 speak to *routine dynamics* and its rising interest on how organizational understandings and routines relate to one another as well as to deliberate change in routines:

- For a *pluralistic setting,* I first employ *the concept of meaning structure* to explore the self-referentiality of organizational understandings and its associating routines (Feldman, 2003; Feldman & Rafaeli, 2002; Rerup & Feldman, 2011).

- Second, it is helpful to *distinguish between central and peripheral routines as well as reflective ones* (see Adler, Goldofas, & Levine, 1999; Gersick & Hackman, 1990). These distinctions help to specify in chapter 4 how a meaning structure reproduces itself through the dynamic relations between the routines and the organizational understanding they express and draw on.

- Third, the *coordinating routine* in chapter 5 exemplifies how a routine *relates different meaning structures* and therefore contributes to the insights of routines as a way of coordinating actors (Dionysiou & Tsoukas, 2013; Feldman & Rafaeli, 2002) and of other routines (Jarzabkowski, Le, & Feldman, 2012; Ockhuysen & Bechky, 2009).

- Fourth, the insights on *routinizing reflection* in chapter 6 contribute to the growing investigations on deliberate routine change (Bapuji, Hora, & Saeed, 2012; Bresman, 2013; Howard-Grenville, 2005; Pentland & Feldman, 2008; Rerup & Feldman, 2011; Stiles et al., 2015). Routinizing reflection exemplifies how adapted and new routines emerge. While addressing the call of investigating routine emergence (Parmigiani & Howard-Grenville, 2011), the model helps to

further elaborate on the deliberate change of routines. Thereby, the model may also offer inspiration for the discussion on relating episodic and continuous change (Langley & Denis, 2006; Weick & Quinn, 1999).

1.7 Relevance for understanding and managing in plurality

Investigating the empirical research interests in a pluralistic setting is also relevant for those organizations that become increasingly pluralistic (Denis et al., 2011; Denis et al., 2001; Denis et al., 2007b; Jay, 2013; Rüegg-Stürm et al., 2015; Schedler & Rüegg-Stürm, 2014). Insights from a hospital can serve as a precursor for those organizations that are moving towards knowledge-intensive work.

The following sections point out the relevance of my three empirical research interests. *My first research interest in chapter 4 is on the improbability of pluralistic organizations*. The improbability results from their pluralistic character of "…multiple objectives, diffuse power and knowledge-based work processes…" (Denis et al., 2007b: 179). While understanding these characteristics in general, previous literature does not focus on how this plurality is accomplished. Some studies explore the challenges of different worldviews enacted by different departments and clinics, e.g., in hospitals (Doolin, 2001; Iedema et al., 2003; Llewellyn, 2001). Others start out with plurality and investigate strategizing (Jarzabkowski, 2004), leadership (Denis, Langley, & Rouleau, 2010), decision-making (Denis et al., 2011), or change (Barley, 1986; Denis et al., 2001; Ericson, 2001; Lozeau et al., 2002). These studies emphasize the importance of pluralism with its resulting challenges and associated forms of handling. They attend less to how pluralism persists within these organizations. The "ways of acting" (Jay, 2013: 140) or "of organizing" (Glouberman & Mintzberg, 2001a: 57) remain under researched.

Understanding plurality in terms of the ways of acting is practically relevant. Such insights provide an important background to act within a specific organization. Depicting the different meaning structures within which organizational members operate helps to understand their activities. Therefore, and together with the theoretical relevance argued above, I explore in more detail how a specific organization reproduces its plurality and thereby its own improbability. Chapter 4 addresses thus the need for a perspective "in which pluralism is viewed as a natural state of affairs" (Denis et al., 2007b: 183).

My second research interest in chapter 5 is on how a pluralistic organization accomplishes stability. This research interest results from the observed impermeability of pluralistic organizations to deliberate change attempts. Among others, Pettigrew (2012: 1312) notes that healthcare organizations have been seen as highly change resistant. The difficulties associated with change relate to the following: unsuccessful sensemaking (Ericson, 2001); misunderstandings (Llewellyn, 2001); escalating perpetuating conflicts (Bate, 2000); avoidance of conflict by continued and escalating in-decision (Denis et al., 2011); resistance (Kellogg, 2011), impossibilities to learn from failures (Tucker & Edmondson, 2003); or undermining effects of previous decisions on current ones (Denis et al., 2001). In comparison, successful hospital change requires early proof to work (Reay et al., 2006), reflection (Edmondson et al., 2001; Iedema & Carroll, 2011; Kellogg, 2011), and active attendance to stabilization (Denis et al., 2001).

The large number of difficulties to change demonstrates that pluralistic organizations are remarkably stable. We know little, however, on how they achieve stability. Understanding how a specific pluralistic organization achieves stability by routinely coordinating different meaning structures is not only theoretically revelatory, as pointed out above, but it is also relevant to practitioners. The situative accomplishment of stability helps to depict the rules of the game by which actors pursue organization-wide issues. These ‘rules of the game’ help organizations to become aware of the possibilities and restraints for moving issues forward. Without such knowledge, deliberate attempts to change risk failure. Beyond the scope of the specific organization studied here, the description of the coordinating routine may trigger others to explore the ‘rules of the game’ within their organization. Identifying the coordinating routine therefore provides an important building block for our understanding of pluralistic organizations. Kraatz & Block (2008: 262) recommend “that the examination of such integrative processes poses a particularly important opportunity...”

My third research interest, reported in chapter 6, is to explore how a deliberate attempt to change a pluralistic organization unfolds. Attempts at change are challenging in a pluralistic organization. Change initiatives alter how organizational members pursue their respective tasks. In addition, change initiatives relate to pluralistic organizational understandings and may therefore involve adaptations within the meaning structures as well. Thus, changing a pluralistic organization like a hospital is a daunting task for

practitioners, which is why I pursue this third interest of how deliberate change attempts can unfold in a pluralistic organization.

Several studies point out the central importance of reflection in such a process. Iedema & Carroll (2011) explore the position of a so-called “clinalyst” to establish continuous reflection and improvement of clinical work. Reay et al. (2006) also suggest that such a new position requires observable “small wins” to establish a new position within a clinic. Edmondson et al. (2001) report on deliberately changing routines in cardiac surgery, noting that the establishment of reflection throughout the implementation of the new routines helps to explain the success or failure (ibid: 705; 707). Similarly, Kellogg (2011) identifies so-called relational spaces. They are informal communicative settings of organizational members who are in favor of a proposed change. Relational spaces allow them to develop a sense of community, to coordinate their actions, and to motivate each other to continue in light of a dominant opposition. As her study of three failures and one success case illustrate, establishing relational spaces is precarious. Finally, and within a top management team, Jay (2013) demonstrates the need for ongoing sensemaking in light of ambiguous outcomes that question the understanding of top managers about what success means for their organization. While these studies point out the central importance of reflection, we still know little about how to establish it as routine throughout the organization. Reflection remains either implicit (Reay et al., 2006) or with regards to mainly treatment but not organizational issues (Edmondson et al., 2001; Iedema & Carroll, 2011) and is viewed as an individual or interactional group affair of top management (Jay, 2013) or of practitioners on the operating floor (Edmondson et al., 2001; Kellogg, 2011).

Further exploration of how reflective routines become established is practically relevant. For practitioners, establishing reflective routines offers a pathway to conducting deliberate change. Reflective routines systematically include organizational members and associate with the proposed and enacted meaning structures that allows working through their contradictory tensions.

1.8 Summary and overview of the coming chapters

Given this theoretical and practical relevance, I explore a pluralistic organization alongside my three empirical research interests focused on the three research questions that invite routine dynamics into the paradox lens. In summary, I first argue that a pluralistic organization is founded on the paradox of differentiation and integration. Second, I investigate the relationship between these poles, which is an informal coordinating routine. This routine handles the paradox and achieves paradox latency. Third, deliberate change within a pluralistic organization evokes the contradictory tensions between a proposed and an enacted meaning structure. In my case, routinizing reflection provides a means to relate these poles and to shift the studied department towards the proposed meaning structure.

Overall, I aim to elaborate on a process perspective on paradox that contributes to the understanding of pluralistic organizations in the following steps: *Chapter 2* contains the arguments for the three research questions to further advance a processual take within the paradox lens by inviting routine dynamics. *Chapter 3* concerns the research practice that describes the organizational setting; the researcher's role and activities to generate qualitative data; the analysis within the single case studies as well as the iterations between literature and data; the boundary conditions; and the validation of the findings. *Chapters 4-6* provide the empirical investigation for generating the insights that have been introduced above. *Chapter 7* provides a summary of the presented insights, the generation of future research options based on the reflection on this study's limitations, and the implications to approach research in collaboration with practice as well as the suggestion that management means to orchestrate reflective routines.

2 Three research questions for the paradox lens that invite routine dynamics through self-referentiality

Self-reference is as simple as an arrow bent into a circle (Kauffman, 1996: 298)

A paradox lens provides a promising starting point for my empirical research interests. However, a processual perspective that depicts the dynamics of organizations as an active accomplishment is still uncommon within this literature. This general observation manifests in three research questions that concern the accomplishment of paradox; the handling of that paradox with its resulting latency; and the embedding of a proposed solution to a paradox within a pluralistic organization. In order to address these research questions from a processual view, I draw on routine dynamics. This literature highlights the dynamic, situative enactment of organizations. Furthermore, routine dynamics builds on mutual constitution (Parmigiani & Howard-Grenville, 2011) and shares the assumption of self-reference from which paradoxes emerge (von Foerster, 1994).

The first section contains an introduction to paradox and routine dynamics literature and an elaboration on self-referentiality. The second section argues the research questions within the paradox literature and shows the potential of routine dynamics therein. The third section is a summary of the research questions in relation to the research interests that express my aim to strengthen the processual perspective within the paradox lens.

2.1 The paradox lens, routine dynamics, and self-referentiality

2.1.1 The paradox lens: Towards utilizing a process perspective

Early work on organizational paradoxes[3] originates from psychology (Watzlawick, Weakland, & Fisch, 1974). In organization studies, Putnam (1986) distinguished contradictory messages on the individual level from self-reinforcing cycles between individuals and system contradiction within the organization. Fostered by Quinn & Cameron (1988), Smith & Berg (1987), and Poole & van de Ven (1989) studying paradoxes in organizations has developed into the paradox lens (Lewis, 2000; Lewis &

[3] Paradox draws on a long tradition in philosophy, logic, and the social sciences (Putnam, 1986; Poole & van de Ven, 1989; von Foerster, 1994), the latter of which is the research stream this study refers to.

Smith, 2014; Smith & Lewis, 2011). A core achievement is the departure from theoretical assumptions that highlight coherence over incoherence (Hernes & Weik, 2007; Quinn & Cameron, 1988), linearity over interdependence (Abbott, 1988; Ford & Backoff, 1988), and single over plural rationality in theorizing organizations (Lewis & Kelemen, 2002). In other words, "… paradoxes are at odds with the prevalent view of organizations as coherent entities." (Jarzabkowski et al., 2013: 246).

Paradoxes are "contradictory yet interrelated elements that exist simultaneously and persist over time" (Smith & Lewis, 2011: 382). Paradoxes contain two main characteristics (Ortmann, 2004; Putnam, 1986; Smith & Berg, 1987): contradiction and self-reference.[4] Whereas *dilemmas* share the opposition of two components, they do not involve self-reference (Lewis, 2000; Neuberger, 2000; Smith & Lewis, 2011). In a paradox, the opposing poles relate self-referentially, so that the two poles mutually constitute each other (Clegg et al., 2002). A paradox denotes duality, whereas a dilemma depicts dualism (Farjoun, 2010; Smith & Lewis, 2011).

A paradox lens draws attention to social phenomena that do not bear a rational solution. A first contribution is to approach such a situation as an opportunity to envision and to enact creative alternatives (Beech et al., 2004; Ford & Backoff, 1988). Many studies have focused on individuals and groups that generate solutions to paradoxes (Lewis, 2000; Lewis & Smith, 2014; Luescher & Lewis, 2008; Smith & Lewis, 2011). A core insight is learning to think paradoxically (O'Connor, 1995; Westenholz, 1993) and to accept paradoxes as invitations to act (Beech et al., 2004) to alter the interaction patterns from which a paradox emerges (Barley, 1986; Barrett et al., 1995; Luescher et al., 2006).

A second contribution is the shift from handling paradoxes by choosing between poles (either-or) to leaving both poles intact in both-and approaches (Clegg et al., 2002; Poole & van de Ven, 1989). Either-or approaches separate the opposing poles either in space by drawing boundaries and creating departments, divisions, or other types of subsystems (Lewis, 2000); alternatively, either-or approaches imply to attend to the opposing poles sequentially over time. The literature often considers either-or approaches as short-term solutions that bear the risk of increasing the tension between the poles (Clegg et al., 2002). In comparison, scholars view both-and solutions to create a dynamic equilibrium

[4] Smith & Berg (1987: 14) note self-reinforcing cycles as a third element. Since they result from self-reference (Ortmann, 2004; Neuberger, 2000) they are part of it and manifest in vicious or virtuous circles (Smith & Lewis, 2011).

(Smith & Lewis, 2011), to move the organization forward (Jay, 2013), or to provide workable solutions (Luescher & Lewis, 2008), thus tapping into the creative potential of the paradox (Ford & Backoff, 1988).

Third, the literature associates either-or and both-and approaches with dualism and duality, respectively (Farjoun, 2010; Ortmann, 2004; Smith & Lewis, 2011). As a dualism, the focus is on the poles and their mutual contradiction. As a duality, the poles are also complementary (Farjoun, 2010). Dualism fosters a choice between the poles as in a dilemma (Lewis, 2000). Duality motivates to keep the poles intact by considering their relation (Clegg et al., 2002). One example is the duality of structure and action by Giddens (1984) in which structures enable and restrict action as action draws on and thereby reconstitutes the structure (Farjoun, 2010; Feldman & Orlikowski, 2011). Another example reconstructs the study by Orlikowski (1996) on situated change (Clegg et al., 2002). These authors argue that improvisation relates the poles of action and structure, which means planning while one acts (Weick, 1993).

Fourth, scholars find that the persistent and dynamic relation of opposing poles is situatively and locally enacted. As the poles mutually reinforce each other their "… relationship is a local one, in the sense that it cannot be designed generically – it emerges from situated practice" (Clegg et al., 2002: 486). Likewise, Lewis & Smith (2014) argues for the importance of the dynamic processes and mirror the call for a process perspective within the paradox lens (Jarzabkowski et al., 2013).

Recent developments point in two directions. First, scholars map different paradoxes. These works distinguish individual, group and organizational levels to locate paradoxes, including paradoxes that result from relating paradoxes (Lewis, 2000; Smith & Lewis, 2011). This development has received critique, for example, by Jarzabkowski et al. (2013: 250, emphasis added), which points to the second direction: "it is critical to go beyond Smith and Lewis (2011) framework of matched pairs in order to *understand the dynamics through which paradoxes are interlinked* and the way they generate outcomes that shape the ongoing response to paradox."

Jarzabkowski et al. (2013) call for a processual perspective within the paradox lens, and this represents the second direction of recent developments. Lewis & Smith (2014: 15) observes that studies "depict the dynamic and mutually constitutive relationship between

alternative poles of a paradox." One of the process studies has investigated the evolution of organizational understanding (Jay, 2013). This research highlights the continuous sensemaking over time to reframe the top management's understanding in response to paradoxical environmental cues. Another study by Jarzabkowski et al. (2013: 255) finds a wide range of responses, including suppressing, confronting, and accepting a paradox within a single setting. Andriopoulos & Lewis (2009) reveal that handling paradoxes contains both differentiating and integrating managerial practices. Differentiating practices emphasize the distinguished parts of an organization and their unique contributions. Integrating practices highlight the relationships between the parts and their mutual benefits. Abdallah et al. (2011) explore the dynamic resulting from how managers reconstruct the paradox in their communication with organizational members. The managers' so-called discourses of transcendence aim to reinterpret the paradox. Discourses of transcendence draw on ambiguity to maintain commitment and unity in situations of difference, and thereby simultaneously provide the conditions of their own dissolution. Recently, Smith (2014) identifies consistently inconsistent decision-making of senior managers as a paradoxical solution to handle paradoxes. In her case, managers employ paradoxical decision-making patterns to handle paradoxes.

These works strengthen a processual perspective within the paradox literature. They stress the dynamics of a paradox and its handling over time. Building on these insights, I explore empirically how a paradox is accomplished and handled within a pluralistic organization, and in what ways solutions to a paradox can be embedded. For these research interests, routine dynamics provides promising insights because it addresses the situative and the local enactment of organizational paradoxes.

2.1.2 Routine dynamics: Organization as active accomplishment

Routines are a major means by which organizations pursue their tasks. Feldman (2000) and Pentland (Feldman & Pentland, 2003) introduced the dynamic view of routines as "generative systems" (Feldman & Pentland, 2008). They extended and challenged the

common view of routines[5] and argued for endogenous change and stability of routines as an active accomplishment (Feldman, 2000).

Routines as generative systems are recognizable repetitive patterns of actions to which multiple actors contribute. This notion highlights the internal dynamics of a routine that leads to both change and stability (Feldman & Pentland, 2003; Feldman & Pentland, 2008). Two interwoven dimensions drive this dynamic: a routine contains a performative dimension that is specific actions of specific people in specific times and places. The ostensive dimension is the pattern of these performances, called the routine in principle (Feldman & Pentland, 2008). It is both explicit and implicit as well as multiple, because different actors may understand a routine differently (Cohen, 2007; Dionysiou & Tsoukas, 2013; Feldman & Pentland, 2003; Feldman & Pentland, 2008).

Numerous studies often focus on single routines that I broadly sort into three groups. The first group investigates routines of production and service provision that contribute directly to the specific value creation of an organization (Bapuji et al., 2012; Feldman, 2000; Turner & Rindova, 2012). The second group explores administrative routines that provide resources for an organization's production or service provision, for example hiring or budgeting (Feldman, 2003, 2004; Jarzabkowski et al., 2012; Pentland, Haerem, & Hillison, 2011; Rerup & Feldman, 2011; Stiles et al., 2015; Zbaracki & Bergen, 2010). The third group comprises routines that reflect on other routines, as in learning, problem-solving or developing routines (Adler et al., 1999; Bresman, 2013; Howard-Grenville, 2005; Pentland & Feldman, 2008). These studies share a view on routines and organization as active accomplishments (Feldman, 2000). They express in detail how organizations and their members pursue specific tasks in terms of repetitive recognizable patterns of action involving different interdependent actors (Feldman & Pentland, 2008).

More recently, routine scholars extend their focus to the organizational context of routines (Howard-Grenville, 2005), the understandings of the organization that encompasses the task-level of routines (Feldman, 2003; Rerup & Feldman, 2011), the inter-relation between routines (Feldman & Rafaeli, 2002; Jarzabkowski et al., 2012), the role of artefacts in routines (Bapuji et al., 2012; Cacciatori, 2012), and attend to the emergence of routines and their deliberate change (Bapuji et al., 2012; Dionysiou &

[5] The traditional perspective views routines as stable and repetitive elements crucial for the reproduction of an organization (Becker, 2004; Cohen et al., 1996; Nelson & Winter, 1982) that would change in response to exogenous shocks like new technologies or market shifts requiring routine adaptation (Nelson & Winter, 1982: 130).

Tsoukas, 2013; Feldman, 2003; Pentland & Feldman, 2008; Stiles et al., 2015). These works address the recent calls in the literature to advance routine dynamics as generative systems (D'Adderio, Feldman, Lazaric, & Pentland, 2012; Parmigiani & Howard-Grenville, 2011). Of these developments, particularly the relation between the routine and the organizational understanding, the routinized inter-relation between routines and the deliberate change of routines are important for my research.

2.1.3 Self-referentiality: Relating paradox and routine dynamics

Routine dynamics and the paradox lens share the assumption of self-referentiality. Paradoxes emerge from self-reference (von Foerster, 1994), and the opposing poles form a duality (Farjoun, 2010; Smith & Lewis, 2011). In routines, the ostensive and performative dimensions relate in a mutually constituting way (Feldman & Pentland, 2003; Feldman & Orlikowski, 2011).

This section elaborates on self-referentiality by drawing on second-order cybernetics. Second-order cybernetics provides a theoretical underpinning to relate paradox and routine literature in a conceptually coherent way that is consistent with process research (Hernes & Bakken, 2003; Knudsen, 2011; Vanderstraeten, 2001).

The German sociologist Günther Ortmann (2004) defines self-reference or self-referentiality as something referring to itself. This definition departs from a passive entity (the something) and differs from feedback (Vanderstraeten, 2001). Feedback "involves the generation of information about system conditions that flow back to the system to control it" (Feldman & Orlikowski, 2011: 1242). Therefore, feedback is not integral to a system or essential in generating the system. In comparison, self-reference implies relations in which different elements or components constitute each other. "Relations of mutual constitution produce the very system of which they are part" (ibid.). Mutual constitution corresponds with the concept of autopoiesis by Maturana & Varela (1980) prominent in second-order cybernetics. Autopoiesis is the label for living systems that reproduce themselves in that the elements of an organism produce the boundaries which enable the elements to continue operating.

As depicted in Figure 2-1, self-reference implies a processual view in which the referring (dotted lines) generates the elements (dotted rectangles) and vice versa. The elements constitute each other and form a duality (Farjoun, 2010; Rüegg-Stürm, 2001).

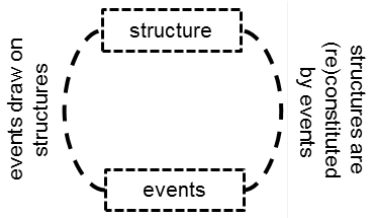


Figure 2-1: Self-referentiality

I define an 'event' as any particular occurrence that one can perceive, such as an object, an action, or a communicative utterance (see Barnes, 1983; Luhmann, 1984; von Foerster, 1994). Structures are the compatible or mutually held expectations in relation to perceived events (Dionysiou & Tsoukas, 2013; Luhmann, 2000). Structures include rules, patterns, and understandings (Hernes, 2014; Rüegg-Stürm, 2001). Structures are repetitive over time, whereas events are elusive elements in time and seize as they emerge (Luhmann, 2000; Rüegg-Stürm, 2001; Schoenenborn, 2011). Events and structures relate in a mutually constitutive way. Events draw on the structure (Feldman & Orlikowski, 2011). Thereby, events reproduce the structure, while the structure provides guidance to sort and associate the events with a certain structure (Barnes, 1983; Feldman & Pentland, 2003). Thereby, structures channel the probability of certain events to occur rather than others (Luhmann, 1984) indicated by the lines in Figure 2-1.

Self-reference in these terms of mutual constitution assumes that the world is made up of events (Hernes, 2014; Schoenenborn, 2011), which we carve out as we observe these events with the help of expectations (structures) that guide our observation (Chia, 2000; Rüegg-Stürm, 2001; Weick, Sutcliffe, & Obstfeld, 2005). Thus, events and structures constitute each other. Their self-referential relationship defines their observed identity (Barnes, 1983; Maturana & Varela, 1980; von Foerster, 1984). Events such as actions or communications draw on structures and reconstitute these structures simultaneously. Therefore, events and structure cannot be understood without the other (Feldman & Orlikowski, 2011).

Mutual constitution concerns the situative self-reference in moments of time and over time. Events connect through structures and form processes (Luhmann, 2000). An event draws on a previously enacted structure and thereby enacts this structure: "in their

ongoing and situated action, actors draw on structures that have been enacted previously […] and in such action reconstitute those structures." (Feldman & Orlikowski, 2011: 1247). Mutual constitution implies that both the event and the structure become medium and outcome to one another (Tsoukas & Papoulias, 2005; von Foerster, 1984, 1994).

For *routine dynamics*, self-referentiality manifests in the duality of a routine's performative dimension and the ostensive dimensions (Feldman & Pentland, 2003). Performing a routine draws on and thereby enacts the understandings of a routine. Vice versa, these ostensive dimensions orient and guide the performance of routines.

The *paradox lens* notes self-reference by definition in that the poles of a paradox are contradictory but interrelated and persist simultaneously (Smith & Lewis, 2011). Either one can only exist because of the other (Clegg et al., 2002; Poole & van de Ven, 1989; Putnam, 1986). The poles of a paradox form a duality, which the literature often displays with the yin-yang metaphor (Lewis, 2000; Smith & Lewis, 2011). Research on both-and approaches (Abdallah et al., 2011; Andriopoulos & Lewis, 2009; Clegg et al., 2002; Luescher & Lewis, 2008; Smith, 2014) illustrates the circular causality of self-referentiality (Kaufman, 1996). It is an alternative to linear causality that speaks of cause and effect, or problem and solution, and both do not apply to self-referential phenomena (Luhmann, 2000; von Foerster, 1994).

Routines and paradoxes entail a self-referential relationship between events and structures. Therefore, self-referentiality provides a mechanism by which to explain empirically observed patterns of organizational phenomena (Langley, 2009; Langley & Tsoukas, 2010). The shared assumption is illustrated in the left side of Figure 2-2:

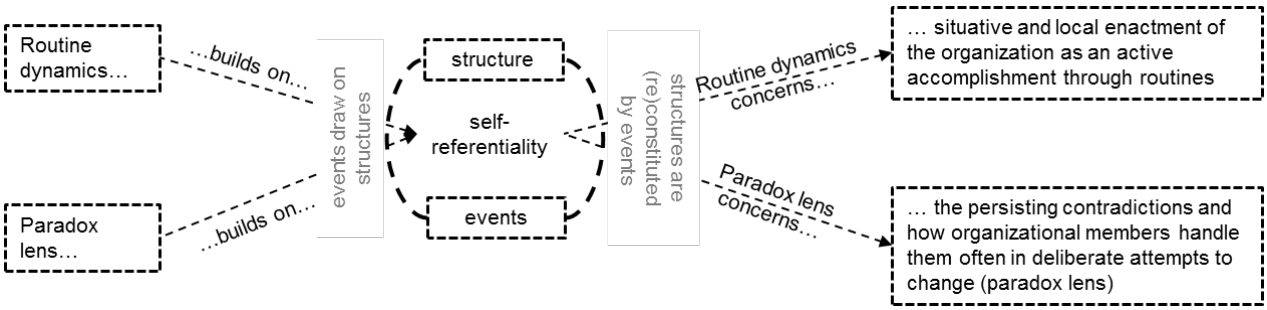


Figure 2-2: Self-referentiality in routine dynamics and the paradox lens

The right side of Figure 2-2 denotes that routines and paradoxes tend to associate with a different yet complementary aspect. *Routine dynamics* highlights that an organization is an active accomplishment (Feldman, 2000). An organization is enacted situatively and

locally through the (non-) routine actions its different members perform (Feldman & Pentland, 2003). Therefore, stabilization and change are integral and endogenous to the everyday practice so that an organization continues operating (Farjoun, 2010; Orlikowski, 1996). Routine dynamics explores how organization as an accomplishment occurs in and over time.

In comparison, the *paradox lens* highlights the tensions and contradictions of the ongoing organizational practice. These tensions and contradictions emerge because organizationally enacted structures are incoherent (Hernes & Weik, 2007) and incorporate different understandings as in ostensive dimensions of routines (Cohen, 2007). The paradox lens explores how organizational members handle these persisting tensions and contradictions (Beech et al., 2004), which often involves attempts to deliberately change how the organization operates (Langley & Denis, 2006).

In summary, the assumption of self-reference allows to relate routine dynamics and the paradox literature. Drawing on routine dynamics helps to address the open issues of the paradox lens that trigger my three research questions.

2.2 Three research questions approached with routine dynamics

The paradox literature offers a promising approach to my research interests. At the same time, the literature poses three open issues that are relevant to a processual view within a paradox lens and that relate to my research interests on pluralistic organizations:

1. An important and current open issue within the paradox lens is the *struggle of how to embed solutions to a paradox* within a specific organization (Jarzabkowski et al., 2013; Jay, 2013; Luescher & Lewis, 2008; Smith, 2014). This open issue relates to my research interest on conducting change in a pluralistic organization in Chapter 6.

2. A first reason for the struggle of embedding paradoxical solutions is that existing studies hardly attend to the *prior solution* that a proposed new one aims to alter. The literature assumes paradoxes to be integral to organizations, so that the relationship between the opposing poles is said to be latent. Studies hardly explore the latency of paradox and do not attend to the enacted relationship between the poles prior to a

paradox's salience. My research interest on how a pluralistic organization achieves stability investigates this open issue in Chapter 5.

3. A second reason for the struggle of implementing paradox solutions is associated with my research interest on depicting the ways of enacting plurality. Studies on paradoxes often point out the contradictions and tensions between the poles of a paradox. But they rarely *explore these poles* in *context-specific detail* to grasp their internal coherence that provides the background for their incoherence when they adjoin. Therefore, I explore different parts of a pluralistic organization from which paradox emerges in chapter 4.

Mirroring the three research interests, I argue the respective research question for the paradox literature and the use of routine dynamics in the following three sections.

2.2.1 The improbability of pluralistic organizations: A paradox view

This section contains the line of argument for the first research question, summarized in the Figure 2-3 (see also appendix table 8.1.1, p. 218):

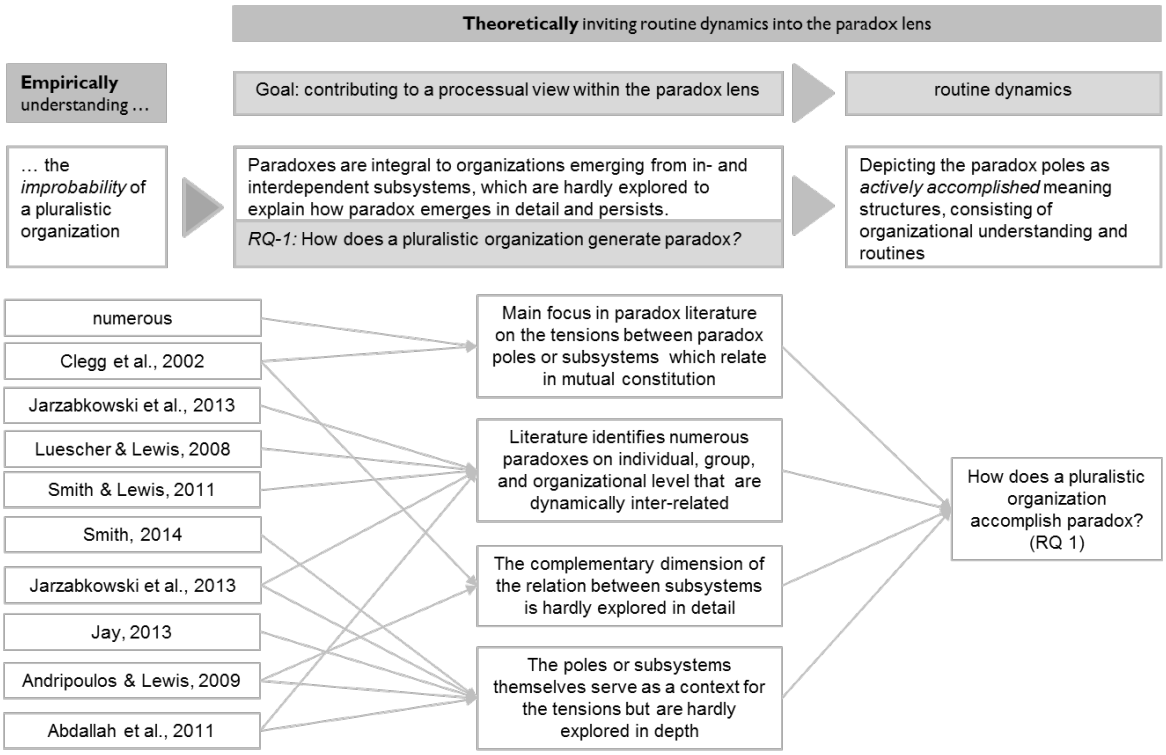


Figure 2-3: Overview on research question 1

Regarding the improbability of a pluralistic organization, the paradox lens considers it a complex and inconsistent system (Poole & van de Ven, 1989: 575). It is composed of

relatively independent subsystems, for example, the clinics and departments of a hospital (Luescher et al., 2006). At the same time, the organizational subsystems "depend on each other" (Clegg et al., 2002: 494). The independent subsystems appear coherent within themselves but incoherent when they adjoin (Luescher et al., 2006). Therefore, the paradox lens assumes that paradoxes are integral to organizations (Lewis & Smith, 2014; Smith & Lewis, 2011).

The paradox lens hardly explores the different subsystems in detail to depict how they sustain their relative internal independence. Sustaining the subsystems accomplishes their relative independence while strengthening the tensions of their interdependence (Lewis, 2000). Therefore, understanding how the sub-systems sustain themselves provides important empirical information to the assumption that paradoxes are integral to organizations. Given that paradoxes are context specific (Clegg et al., 2002) and involve tensions that trigger to act upon them (Beech et al., 2004), it is puzzling how the sub-systems achieve their persistence. Accordingly, I pursue the first *research question:* How does a pluralistic organization generate paradox?

Routine dynamics helps to approach this research question and to depict the active accomplishment of sub-systems through routines and organizational understanding (Feldman, 2003; Rerup & Feldman, 2011). Together, routines and organizational understanding form a meaning structure (Hernes, 2014). Exploring the meaning structures of different clinics and departments helps to understand how the different subsystems reproduce themselves. Inviting routine dynamics into the paradox lens thereby helps to investigate the improbability of pluralistic organizations.

The insight of sub-systems as meaning structures is essential to inform potential ways of handling that paradox and their implementation. Proposed solutions are interpreted within the subsystems' meaning structures and therefore risk misunderstanding and conflict (Bartunek & Moch, 1994; O'Connor, 1995; Westenholz, 1993), particularly in pluralistic settings (Ericson, 2001; Lozeau et al., 2002). Therefore, it is important to understand how the subsystems accomplish themselves within a specific organization despite the tensions and conflicts they entail (Lewis, 2000).

Elaborating on this introduction, I first attend to the conceptual argument of how organizational paradox associates with related sub-systems. Second, I highlight that the paradox literature identifies a wide range of paradoxes. However, many of these

empirical studies and the processual models so far do not depict in detail the sub-systems' internal coherence that provides the basis for organizational paradoxes. Third, I suggest that routine dynamics offers a point of departure to depict the sub-systems or paradox poles as meaning structures.

2.2.1.1 The independence and interdependence of sub-systems

The paradox lens views a paradox as "contradictory yet interrelated elements that exist simultaneously and persist over time" (Smith & Lewis, 2011: 382). Paradoxes result from organizational distinctions that generate different sub-systems (Ford & Backoff, 1988), which are both independent and interdependent (Lewis & Smith, 2014). Each subsystem may appear coherently rational within itself, but "absurd and irrational when appearing simultaneously" (Lewis, 2000: 760). Paradoxes are thus integral to organizations and arise "from the interplay among complex, dynamic and ambiguous systems" (Lewis & Smith, 2014: 6; also Luscher et al., 2006; Rasche, 2008).

Pluralistic organizations resonate with this line of thought (Lewis & Smith, 2014). Each of the multiple and relatively autonomous clinics or departments may be coherent within themselves. Thus, surgery makes sense within surgery, inner medicine within inner medicine, or nursing within nursing. These sub-systems can operate independently, but at the same time, "success of the overall system depends on their interdependence" (ibid.: 132). When the sub-systems interrelate in pursuing organization-wide issues, the differences in goals, functions, expectations, and ways of acting become salient. These differences may turn into opposition and conflict that express the paradox of independent and interdependent sub-systems.

2.2.1.2 Addressing the tensions between rather than the sub-systems

Many studies on paradoxes highlight the tensions between opposing poles without elaborating in detail on the respective poles. The researched paradoxes include management (Neuberger, 2000) and strategic management (Rasche, 2008), global and local contexts (Grand, 1997), centralization and decentralization (Beech et al., 2004; Hundsnes & Meyer, 2006; Mitterlechner, 2007), differentiation and integration (Glouberman & Mintzberg, 2001a, b; Lawrence & Lorsch, 1967), flexibility and efficiency (Adler et al., 1999), competition and cooperation (Chen, 2008), exploration and exploitation (Andriopoulos & Lewis, 2009), change and stability (Ericson, 2001; Farjoun, 2010; Seo, Putnam, & Bartunek, 2004), including privatization (Abdallah et al.,

2011; Davis, Maranville, & Krzysztof, 1997; Tsoukas & Papoulias, 2005), restructuring (Jay, 2013), participation (O'Connor, 1995), different stakeholder demands and self-understandings (Jay, 2013), or strategic contradictions (Smith, 2014; Smith & Tushman, 2005). Most of these studies focus on the tension between the poles of the respective paradox. But these works hardly engage in detail on the internal enactment of the respective poles.

Similarly, recent models attend less to how a paradox emerges as a result of different sub-systems within an organization. Clegg et al. (2002) elaborate on the paradox of action and structure from an individual perspective but without addressing the potential inconsistencies of the structure in question and of structure in general (see Hernes & Weik, 2007). Luescher & Lewis (2008) explore how middle-managers engage in working through paradoxes to generate potential solutions to experienced tensions. Their study hardly reports on the specific context in which these tensions emerge. The dynamic equilibrium model by Smith & Lewis (2011) draws on a wide range of paradoxes to generate a cyclical model that helps to point out a pathway for sustainable development. These authors (ibid.: 389) note the organizational complexity in which "contradictory yet interrelated elements are embedded". Their model focuses on the tension between the interrelated elements but less on how these elements accomplish themselves. Likewise, the conceptualization by Jarzabkowski et al. (2013) hardly incorporates the different department's understandings and ways of acting in their study. Their empirical data focuses on the tensions between the departments and their responses over time through which they depict a cyclical model of mutually reinforcing paradoxes. The study of Jay (2013) provides more details on the different poles of the paradox. This work points out the different metaphors by which organizational members describe and understand their organization. The different poles serve rather as starting conditions to the process model of a continuously evolving organizational understanding.

In summary, the cited studies tend to focus on the tension between different poles or elements that form a paradox, but they attend less to how these poles or elements enact themselves. This dynamic enactment of paradox remains under researched. Accordingly, my first research question is: how does a pluralistic organization generate paradox?

2.2.1.3 Meaning structures to depict the accomplishment of sub-systems

I address this research question by attending to the different sub-systems of a pluralistic organization. These are the clinics and departments of a hospital, and I aim to illuminate how they accomplish themselves. These sub-systems denote meaning structure (Hernes, 2014: 111): "Meaning structures are not merely related to the organization in question: they are the organization. They are enacted by being connected and reconnected by actors into meaningful wholes that are de facto the organization as those actors perceive and act upon it."

I suggest that a meaning structure is composed of the routines situated on a task level and the organizational understanding that encompasses the task level (Rerup & Feldman, 2011). The organizational understanding is "the shared assumptions about the organization" (Feldman & Rafaeli, 2002: 317). The organizational understanding provides the members with cues to interpret perceived events similar to organizational schema (Balogun & Johnson, 2005; Bartunek & Moch, 1987; Feldman, 2003; Rerup & Feldman, 2011). Routines, in turn, draw on the organizational understanding and thereby enact it so that both form a duality (Feldman, 2003).

In summary, the paradox lens is promising to understand the improbability of pluralistic organizations, but the context-specific ways in which the different sub-systems or paradox poles accomplish themselves remains under researched. Addressing this niche invites the works of routine dynamics that relate organizational understanding and routines, which I argue form meaning structures.

Understanding how different meaning structures enact themselves is relevant for a pluralistic organization like a hospital. Here, we encounter numerous understandings of the organization and respective routines that characterize the organization as pluralistic (Denis, Langley, & Rouleau, 2007a; Glouberman & Mintzberg, 2001a; Jarzabkowski & Fenton, 2006; Vogd, 2004). With regards to the discussion on paradox, insights into how subsystems as meaning structures enact themselves helps to understand how paradox persists in a pluralistic setting. Thus, exploring the plurality of meaning structures helps to illuminate on the improbability of pluralistic organizations.

2.2.2 The stability of pluralistic organizations: paradox latency

My second research interest on pluralistic organizations is to explore their stability. The paradox literature shows that proposed changes are interpreted within the meanings structures of different sub-systems (Bartunek & Moch, 1994; O'Connor, 1995; Westenholz, 1993) risking defensive responses (Lewis & Smith, 2014). The paradox becomes salient in such situations of change besides experiencing resource restrictions and plurality (Smith, 2014). Prior to its salience, a paradox is said to remain latent (Lewis & Smith, 2014; Smith, 2014; Smith & Lewis, 2011). Figure 2-4 offers an overview for research question 2 (see also appendix 8.1.2, p. 220):

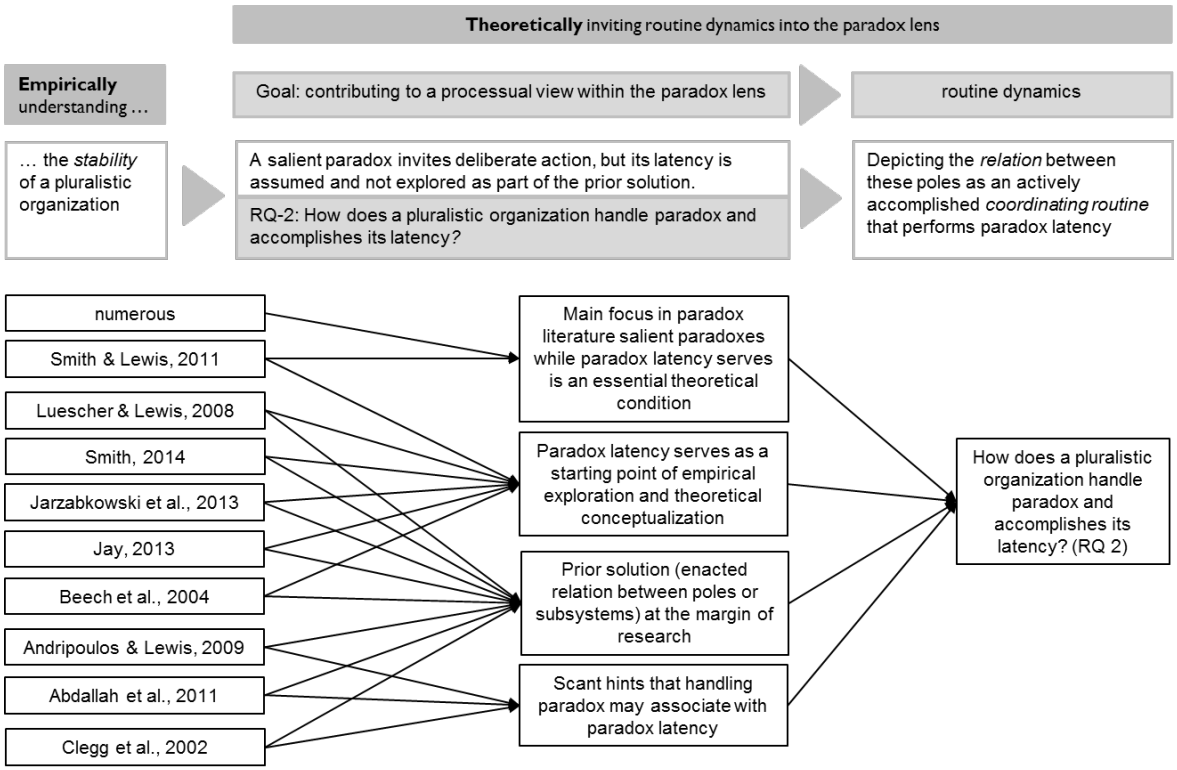


Figure 2-4: Overview on research question 2

The paradox lens assumes paradox latency without specifying what latency means or how it is accomplished (Lewis & Smith, 2014). If paradoxical poles relate, by definition this enacted solution involves paradox latency because paradoxes are not salient all the time. Many studies on paradoxes do not address the enacted prior solution. Rather, they start with once a paradox is salient. Therefore, we still know little about paradox latency and how it is accomplished as part of the relationship between the poles, or subsystems, respectively. My second research question is the following: How does a pluralistic organization handle paradox and accomplishes its latency? I address this research question on the prior solution and paradox latency by drawing on the routine dynamics

literature. Routines serve as coordinating mechanisms that relate actors and other routines (Feldman & Rafaeli, 2002; Jarzabkowski et al., 2012; Ockhuysen & Bechky, 2009). Thereby, routines are a means to stabilize the organization.

Understanding paradox latency and its accomplishment is relevant for pluralistic organizations and for the paradox lens. For the latter, explaining paradox latency complements the assumption that paradoxes are integral to organizations despite not being permanently salient. Furthermore, the prior solution and its latency provide an essential background for envisioning and embedding alternative solutions. For pluralistic organizations, this research elaborates on how such an organization accomplishes stability. I thereby complement existing explanations of the observed impermeability of pluralistic organizations to deliberate change (see chapter 1).

Subsequently, I first discuss the conceptual relevance of paradox latency. Then, I argue why the paradox lens has previously rarely attended to paradox latency. Third, I suggest that the concept of coordinating routines offers a promising point of departure.

2.2.2.1 The conceptual importance of paradox latency

Since paradoxes are integral to organizations but are not salient all the time, they often remain latent (Lewis & Smith, 2014; Smith, 2014; Smith & Lewis, 2011). Paradox latency is thus an important underpinning of the theoretical concept of a paradox lens. The literature often mentions the latency of paradox as a starting point and highlights the conditions under which a paradox becomes salient. “Although inherent tensions may remain latent in organizations, they surface or become salient as actors emphasize differences over commonalities” (Lewis & Smith, 2014: 133).

Researchers identify at least three circumstances for paradox salience (Smith & Lewis, 2011: 390): First, *plurality* points out different goals and perspectives that emerge from and within sub-systems and that turn into tension when they adjoin. Second, *deliberate change* brings differences between an enacted organizational understanding and a proposed one to the foreground. These differences often lead to conflict because the proposed understanding is interpreted according to the enacted one (Balogun & Johnson, 2005; Bartunek & Moch, 1994; Luescher & Lewis, 2008; O'Connor, 1995; Westenholz, 1993). Third, the experience of *resource restriction* (e.g., on funds, human resources, time, material infrastructure) triggers the salience of paradox because such issues often

call forth selective choices (Lewis & Smith, 2014). In summary, plurality, change, and resource restrictions trigger differences and tensions (Denis et al., 2001).

2.2.2.2 The latency of latency in empirical studies and theoretical models

Studies hardly explore the initial situation prior to paradox salience. In addition, the meaning of "latent" remains vague.[6] It points to invisibility (Schoenenborn, 2011) and to laying "dormant" (Pratt & Foreman, 2000: 20). The cues in the paradox literature imply the following: First, managers' deliberate attempts to reinterpret paradoxical tensions to handle a salient paradox can make it latent (Abdallah et al., 2011). The managers in their study promote ambiguity and quasi-conflict resolution that enhances unity within differences "so that contradictions or paradoxes that were previously seen as intractable appear to be *dissolved* or overcome" (ibid.: 335, emphasis added). Second, Andriopoulos & Lewis (2009) provide implicit cues on paradox latency in their study on exploration and exploitation. To relate these two poles, the practitioners utilize a pragmatically idealist vision and describe the handling of loose and tight customer relations as "purposeful improvisation" (ibid. 705); but, they do not describe these insights in detail. Third, paradox latency associates with the relation between the poles of a paradox. "Choosing and finding a balance between the two extremes of a paradox or replacing that tension with a synthesis helps managers to push important dynamics *out of the realm of attention*"(Clegg et al., 2002: 488). These scant references to paradox latency concern the deliberate attempt to handle paradoxes.

These studies do not address paradox latency as part of the enacted relation between the poles that renders the paradox latent before it becomes salient. Rather, different studies begin with paradox salience and often pursue how organizational members cope with a salient paradox. For example, Beech et al. (2004) investigates the paradox of centralization and decentralization within the British healthcare sector with a detailed account of how to handle the paradox as it becomes salient through introducing a respective change initiative. Their data includes the paradoxical poles but does not elaborate on how they relate prior to becoming salient. In the work of Luescher & Lewis (2008), the organizational members work through a paradox to generate so-called workable solutions. Their data starts with the perceived problem descriptions without elaborating on the prior situation in detail. Similarly, Jarzabkowski et al. (2013) takes the

[6] In everyday language, the term is "used to describe something (such as a disease) that exists but is not active or cannot be seen" (Webster's dictionary, 12.03.15; www.merriam-webster.com).

initiative of restructuring a company as a starting point through which paradoxes become salient and dynamically relate over time (ibid., 248). This study highlights different response patterns without attending to how these paradoxes were handled prior to their salience. Exploring the paradox of exploration and exploitation, Smith (2014) reports on different leadership practices of differentiation and integration. These practices accentuate the paradoxical poles as a pattern of consistently inconsistent leaders' decision-making. But the study does not refer to the potential paradox latency (Abdallah et al., 2011). The cited examples illustrate that paradox research starts with the salience of a paradox and does not attend to paradox latency. These studies hardly address the relation between the poles of a paradox prior to deliberate attempts to change it.

The same limitation mirrors in the theoretical conceptualizations. Recent models attend to paradox latency as part of initiating its handling. The relational model of Clegg et al. (2002) considers paradox latency as a possible deliberate response (ibid: 488) but not as integral to improvisation that is argued to relate the poles of the investigated paradox. The model of paradoxical inquiry (Luescher & Lewis, 2008) refers to paradox latency as part of the initial challenge to learning paradoxical thinking (Westenholz, 1993). The model of mutually constituting paradoxes (Jarzabkowski et al., 2013: 255) considers paradox latency implicitly but without reference in their model (ibid., 265). The dynamic equilibrium model (Smith & Lewis, 2011: 389) connects "latent tensions" with the "resolution to paradox" in the figure but only as a starting condition within the text. Similarly, paradox latency is the point of departure in the processual model of Jay (2013: 147). Paradox latency is not included as integral to handling the paradox over time. In comparison to the other models, Jay (2013) refers to the previous enacted solutions. The study shows the top managers' sensemaking and their emerging organizational understandings in terms of general metaphors.

Overall, the cited studies illustrate the scant attention to the prior solution of paradox and to paradox latency. Paradox latency appears to be rather vague, although it is an important component to the paradox lens. Paradoxes are latent or invisible if the assumption is that they are integral to organizations but not salient all the time. Further advancing the paradox lens calls for attending to paradox latency and to the prior solution which denotes the situatively and locally enacted relationship between the poles.

2.2.2.3 Coordinating routines to explore the relation between paradox poles and latency

Routine dynamics corresponds with the local and situative enactment of paradoxes. This body of literature emphasizes the ongoing accomplishment of an organization. Therefore, routine dynamics complements the paradox lens in order to explore the prior solution of paradox and its latency.

Routines are means of coordination (Ockhuysen & Bechky, 2009). This function resides on two analytic levels, the second of which provides a promising starting point for my research. First, actors relate through performing a routine (Feldman & Rafaeli, 2002). Actors mutually adjust their expectations towards the routine so that these expectations become compatible (Dionysiou & Tsoukas, 2013) even if their understandings of a routine are multiple (Cohen, 2007). Routines are means of coordinating actions and communications of different actors (Ockhuysen & Bechky, 2009).

Second, scholars embarked on exploring the relation between routines (D'Adderio et al., 2012; Jarzabkowski et al., 2012). This research on coordinating routines is also applicable to that of the relation between poles of paradox or between different sub-systems, respectively. Jarzabkowski et al. (2012) explores the emergence and establishment of coordinating mechanisms[7] during organizational restructuring. Such coordinating routines enable "many routines to work together to accomplish organizational goals" (ibid.: 921). Extending the concept of coordinating routines to a pluralistic setting helps to depict how such organizations enact the relation between the opposing poles.

Exploring the latency of paradoxes by turning to coordinating routines focuses the second research interest on how a pluralistic organization accomplishes stability. Attending to the enacted, routinized relation between the different clinics or departments allows depicting the relation between these different sub-systems. I particularly look for a routinized relation between them that performs paradox latency. Such a routine helps to explain the impermeability of pluralistic organizations to deliberate change, and to how a pluralistic organization achieves stability. In addition, illuminating paradox latency substantiates the core assumption of the paradox lens that paradoxes are integral to organizations.

[7] Jarzabkowski et al. (2013: 921) argue that coordinating mechanisms do not pursue a task and are therefore not to be seen as routines. I do not follow this argument; instead, I follow Ockhuysen & Bechty (2009) who consider routine as coordination.

2.2.3 Change in a pluralistic organization: embedding paradox "solutions"

My third research interest is on how a deliberate change attempt unfolds in a pluralistic organization. The paradox literature provides insights into different solutions to paradoxes as well as into steps on how individuals and groups develop such approaches.

However, scholars wonder whether envisioned solutions to paradoxes prompt lasting organizational changes (Luescher & Lewis, 2008), how to engage subordinates in these solutions (Jay, 2013; Smith, 2014), or how paradox solutions become integral to the organization (Jarzabkowski et al., 2013). The open issue of embedding solutions to paradoxes prompts the following *research question:* How can paradox solutions become embedded in a pluralistic organization?

I approach this research question by focusing on reflection that is integral to the paradox and routine dynamics literature. The paradox literature mainly considers reflection of those actors who engage with generating paradoxical solutions. Routine dynamics extends reflection to all actors, including those who enact proposed paradox solutions.

My research question is relevant because it tackles an important current open issue within the paradox literature: Without gaining a better understanding of how paradox solutions become organizational reality, the solutions turn into attempts with unclear impact that undermines the legitimacy for the paradox lens. It is timely to address this research question to show the utility of a paradox lens as a theoretical approach but also as a practically relevant one for pluralistic organizations.

The next subsection starts with the insights on paradox solutions and on how to develop them. This is followed by the open issue of embedding paradoxical solutions, and three reasons to explain the open issue. To address these reasons, reflection provides the point of departure. Figure 2-5 offers a summary of arguing research question 3 (see also appendix 8.1.3, p. 221):

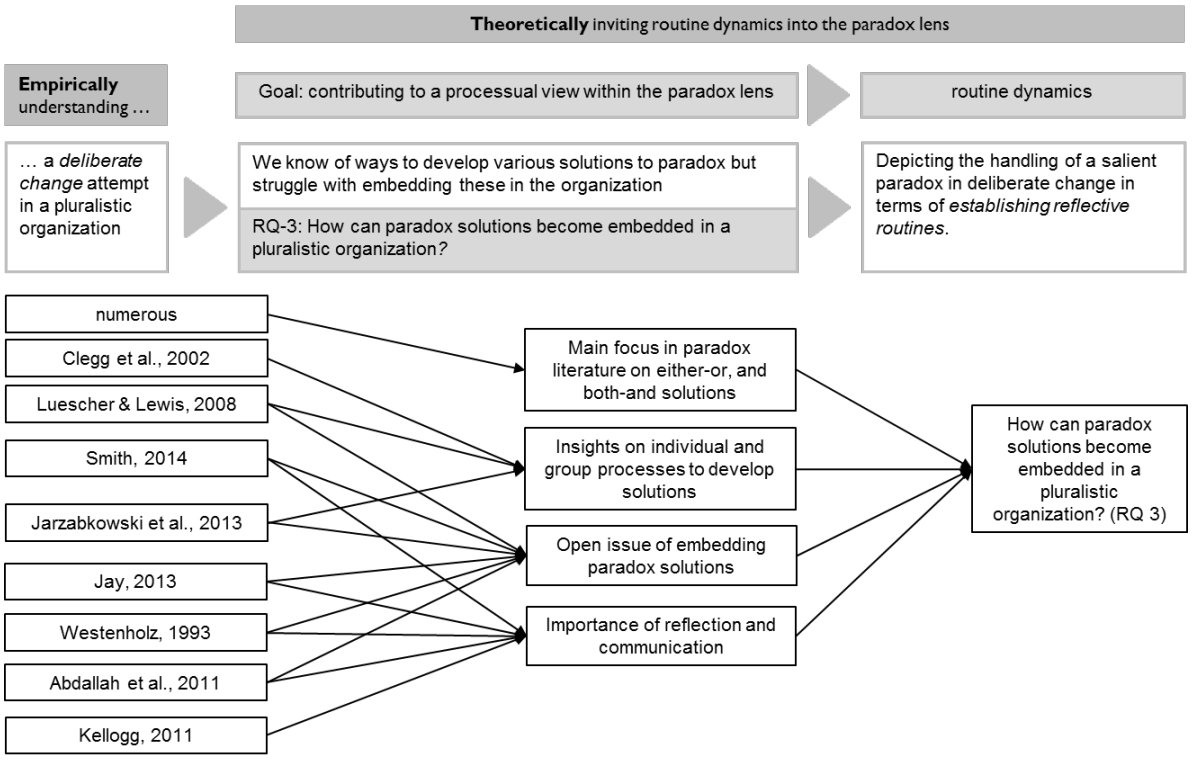


Figure 2-5: Overview on research question 3

2.2.3.1 Solutions to paradox and their development

One of the main contributions of the literature is to identify different ways to handle paradoxes. Poole & van de Ven (1989) suggest to sort these approaches into so-called "either-or" and "both-and" groups:

The either-or approaches indicate the separation of the opposing poles of a paradox temporally or spatially. Scholars suggest that they risk raising the tensions organizational members experience (Lewis, 2000). Because the poles are mutually constitutive, attending to one tends to fuel the demand to also attend to the other pole (Clegg et al., 2002) when organizational members avoid or repress the paradox (Jarzabkowski et al., 2013; Smith, 2014; Smith & Lewis, 2011). Conceptually, separation is said to disconnect the interrelation between the poles although the interrelation is constitutive to the poles of a paradox (Clegg et al., 2002; Lewis, 2000; Luescher & Lewis, 2008). Separation tries to resolve the paradox which by definition is unresolvable. Therefore, the studies prefer both-and approaches as a means of coping with a paradox (Lewis, 2000).

Both-and approaches express that paradoxes cannot be resolved (Beech et al., 2004; Ford & Backoff, 1988; Neuberger, 2000). A *first* approach is *to confront* a paradox that involves the direct communication of a paradoxical tension and "addressing one's own defenses" (Luescher & Lewis, 2008: 232). *A second one is acceptance.* It means to live

with a paradox and "denotes a new understanding of inconsistencies, conflict, and ambiguity as natural working conditions." (ibid.: 234). The involved actors engage with a paradox, which highlights that it is insufficient to think of oneself outside of a paradox but use it as an invitation to act (Beech et al., 2004). Workable certainties result from such immersion and offer temporary ways to handle paradoxical tensions (Luescher & Lewis, 2008). The third approach of accommodating (Smith, 2014) or transcending the paradox (Lewis, 2000; Watzlawick, Beavin, & Jackson, 1985) aims for a new meaning of the paradox to envision a "novel, creative synergy that addresses both oppositional elements together" (Smith, 2014: 1594).[8]

Developing both-and approaches is said to require the capacity to think paradoxically (Westenholz, 1993) in order to create a new understanding of the relationship between the opposing poles. Clegg et al. (2002), for example, argues that improvisation relates the action-structure paradox in continuous change (Orlikowski, 1996). Poole & van de Ven (1989) shows that thinking in terms of duality instead of dualism (Giddens, 1984) provides a theoretical example of transcendence or accommodating. Jay (2013) offers an empirical example of how the Cambridge Energy Agency altered its organizational understanding of success in light of paradoxical outcomes and ambiguous environmental cues. In another study, Luescher & Lewis (2008: 288) depicts "paradoxical inquiry" as a pattern that helped middle-managers to work through their respective challenges at hand. Paradoxical inquiry starts with articulating the perceived problem, continues with exploring the participants' perspective on that problem in order to reflect on the implications and linkages between existing options to handle that problem, and terminates in questions encouraging ongoing experimentation.

2.2.3.2 The struggle to embed paradoxical solutions

Despite these advances, a current open issue is how to embed paradox solutions within an organization. Smith (2014: 1618) reports on how senior managers struggle with engaging employees into their ways of handling paradoxes and points out: "This study further raises the question about how leaders can engage subordinates while embracing paradoxical strategies." The issue of engaging subordinates implicitly applies to studies

[8] The literature does not use the labels for both-and approaches consistently which could invite a future review of the literature. For example, Lewis (2000: 764) talks of "reframing" as a result of critically reexamining entrenched assumptions. Putnam (1986: 160) implies that transcending involves "expanding the space in which the contradiction exists…, synthesizing polar opposites, or viewing the situation from both inside and outside." Beech et al. (2004: 1323) argue for holding open a paradoxical situation, thus resisting the temptation "to achieve intellectually driven closure".

that focus on the top management team. For example, Jay (2013) follows this group's sensemaking in detail over time and depicts their shifting organizational understanding. How these shifts emanate to the organization remains outside the scope of his study. Denis et al. (2001) explore the process of merging hospitals in several cases. The top management team faced "many opposing tensions" (ibid: 832), which is why enacting stability within the top management team becomes important. These insights notwithstanding, the authors call for "much more attention to the flow of leadership and change *throughout the organization*" (ibid: 832, emphasis added). Extending towards the organization by investigating middle managers, Luescher & Lewis (2008: 237) show how paradoxical inquiry works but acknowledge the following: "Yet whether such responses to paradoxes continued and how they affected larger structural changes is unknown." To this end, Jarzabkowski et al. (2013) argue to implement procedures, such as cross-functional teams. A cross-functional team helps to sustain the envisioned way of handling the observed paradox. These authors do not elaborate on how such a team becomes established in detail. The cited studies are important to develop paradox solutions but remain limited as to how these solutions become part of the organization.

This limitation is reflected in the resulting theoretical models. They focus on the individuals and groups who envision paradox solutions. Clegg et al. (2002) remain on an individual level and do not expand to involve others within the organization. The "dynamic equilibrium model" shows that both-and approaches help to avoid vicious circles and to embrace virtuous ones (Smith & Lewis, 2011). These authors draw on paradoxical inquiry (Luescher & Lewis, 2008) and thereby incorporate only the group who envisions solutions to a paradox. Likewise, the conceptualization by Jay (2013) depicts the sensemaking of the top management team in detail but not the way of how the shifts in organizational understanding emanate to other organizational members. As an exception, the model by Jarzabkowski et al. (2013: 265) addresses the embedding of paradoxical solutions. Their cyclical model of responding to paradoxes distinguishes between embedding and not embedding paradoxical solutions over time. These authors conceptualize less on how the embedding occurs in detail despite cues in their empirical data. These cues include separating the poles of the paradox, accentuating difference, escalating conflict, and the organizational members' recognition of interdependence in cross-functional teams (ibid: 257ff.). However, the proposed model remains on the level

of observing whether or not such different solutions to paradox became embedded within the organization.

In the paradox literature, I detect three reasons for the struggle with embedding proposed approaches to paradox within an organization:

A first one is the separation between those designing ways of handling the paradox from those on the receiving end (Bartunek, Rousseau, Rudolph, & DePalma, 2006). Solutions that are generated by certain individuals or groups within the organization bear the risk of being misunderstood by those members who do not participate in their development (Barrett et al., 1995; O'Connor, 1995). Westenholz (1993: 54) points out: “Proponents of paradoxical suggestions, however, in most cases suffer the same fate as all others: he or she is interpreted on the basis of the existing frame of reference.” Those on the receiving end of the designed ways of handling paradox remain outside the processes of learning to think paradoxically (Westenholz, 1993), of paradoxical inquiry (Luescher & Lewis, 2008), or of sensemaking (Jay, 2013). Such a separation prompts defensive reactions (Lewis, 2000). Defensive reactions tend to enhance the experienced paradoxical tensions and conflict (Luescher et al., 2006) leading to escalating vicious circles (Smith & Lewis, 2011). Furthermore, the separation of designers and implementers is particularly problematic in a pluralistic organization like a hospital. Not only do members of different departments or clinics associate with diverse perspectives, but also, designers of paradoxical solutions require the consent of the implementers (Denis et al., 2001), which turns out to be difficult when separating between the two groups.

A second and associated reason is that the prior and currently enacted solution to a paradox is hardly considered. As I demonstrated in the previous section, many empirical studies address the opposing poles and their tensions. These studies do not depict in their data how these poles have been handled so far within the organization. This lack of attention to the prior solution means that the proposed solution omits that which it aims to change. This is not only the paradox but rather the prior solution that has been enacted so far. Without considering the prior solution to a paradox, a proposed one risks to fail its embedding within the organization.

Third, and as a consequence, the relationship of the proposed solution with the enacted one receives little consideration. Similar to an episodic change initiative (Weick & Quinn, 1999), embedding a paradoxical solution means to weave it into the ongoing and

situative accomplishment of an organization (Langley & Denis, 2006). Therefore, a proposed solution relates to the enacted one while simultaneously aiming to shift it towards the proposed solution.

2.2.3.3 Attending to reflection with a routine perspective to embed paradox solutions

Reflection helps to address these previously mentioned reasons. The paradox literature attends to reflection as a means of meta-communication. Here, participants observe the way they communicate (Watzlawick et al., 1985). Meta-communication allows them, for example, to address contradictory messages or double binds (Putnam, 1986), or to construct perceived tensions in terms of paradoxes (Lewis & Smith, 2014) or to address one's own defenses (Luescher & Lewis, 2008). Thus, scholars call for "a forum for discussion where carriers of reference could meet" (Westenholz, 1993: 54), such as paradoxical inquiry (Luescher & Lewis, 2008), cross sectional team (Jarzabkowski et al., 2013), or continuous sensemaking and reflection (Edmondson et al., 2001; Jay, 2013).

The above analysis shows that reflection is often restricted by the separation of designers and implementers. Routine dynamics offers the possibility to extend reflection from the designers of paradoxical solutions to those on the receiving end of a proposed solution. Both groups perform routines and reflect on this performance continuously (Feldman, 2000; Parmigiani & Howard-Grenville, 2011). During routine performance, the organizational members may choose to deviate "whether in response to external changes or in response to reflexive self-monitoring" (Feldman & Pentland, 2003: 108). Reflection is integral to performing routines as the involved actors continuously adjust their respective expectations and understandings (Dionysiou & Tsoukas, 2013). In the case of deliberate routine change, scholars observe actors referring to their organizational understanding (Feldman, 2003) that associates with a routine and vice versa (Rerup & Feldman, 2011). Organizational members jointly reflect on the process of changing a routine (Edmondson et al., 2001; Stiles et al., 2015) and employ learning (Bresman, 2013) or problem-solving routines (Adler et al., 1999). In hospitals, reflective routines are often used to continuously improve clinical practice (Iedema & Carroll, 2011).

Routinizing such reflection is often inhibited by resource restrictions, time pressure, the fear to address problems, and the bias towards quick-fixes instead of exploring underlying causes (Tucker & Edmondson, 2003; Weick & Sutcliffe, 2003). At the same time, reflection is central to learning (Hilden & Tikkamäki, 2013) and tends to occur as

non-routine action integral to trial-and-error learning in non-pluralistic settings (Rerup & Feldman, 2011) or as reflection when adapting treatment routines deliberately (Edmondson et al., 2001). Nevertheless, routine dynamics emphasizes that reflection applies not only to the organizational members that engage in generating proposed solutions to paradox but also to those who enact the proposed solutions.

Despite its importance in both literatures, reflection often remains vague (Zundel, 2012).[9] Second-order cybernetics situates reflection analytically on a second-order level (Maturana & Varela, 1980; von Foerster, 1984, 1994). Reflection means to observe an event, an action, or a communication that resides on a first-order level. Like these first-order topics, reflection is an active operation of observation. Observation in turn is defined as distinguishing and indicating (Spencer-Brown, 1969). Observing means that when we perceive the world, we carve out something from the ongoing flow of undifferentiated flux (Weick et al., 2005). "Carving out" means to distinguish between that which we observe and the rest and to indicate the observed (Spencer-Brown, 1969). Distinguishing as an active performance draws on previously emerged distinctions that serve as structure that include the understandings and views of the meaning structure we use when we observe (Hernes, 2014). Throughout the process of ongoing observation, actors draw on the (meaning) structures (Luhmann, 1984). The structures emerge, establish, maintain, and alter throughout the observing (Barnes, 1983). Thus, observation in general and reflection in particular are self-referential processes composed of events and structures of observing.[10]

Sharing self-referentiality, reflection fits with routine dynamics and the paradox lens. Furthermore, reflection as observation resonates with the insight of routine dynamics that reflection is ubiquitous within the organization. After all, reflection "is an inalienable human capacity" (Holland, 1999: 472). It is integral to the social phenomenon in which it takes place (Czarniawska, 2008; Rüegg-Stürm & Grand, 2014).

[9] Returning to the Latin root, "reflectere" has two connotations: One is the metaphorical view into the mirror through which the observer enters the image and becomes visible within his or her context (Luhmann, 1990); the other association is bending back and looking at one's experience similar to retrospective sensemaking (Weick, 1979; Weick et al., 2005).

[10] Humberto Maturana (in: Maturana &Varela, 1980: 15) describes his study on frog vision in the late 1950s through which they showed that vision is not a representation of reality, but rather an internal construction that allows an organism to live in its environment. Their experimental insight implies that "the external world would only have a triggering role in the release of the internally-determined activity of the nervous system."

This subsection regards my third research interest of deliberate change within pluralistic organizations. The paradox literature helps to depict solutions to paradoxes. More recently, this literature points out the current challenge of how to embed these proposed solutions. Within the paradox literature, reflection is involved in noticing the paradox and in generating "solutions" once the paradox becomes salient and invites action upon it. However, reflection is limited to those who are directly involved in this process. Routine dynamics expands reflection to all organizational members and thereby helps to address the challenge. Therefore, I approach the research question of how to embed paradoxical solutions by focusing on routinized reflection, which is understood as an ongoing second-order observation.

2.3 Summary of the research questions and research interests

In this chapter, I argued three research questions for the paradox lens and drew on routine dynamics to address them: *The first question on how a pluralistic organization generates paradox* leads me to explore different meaning structures within a specific organization. Meaning structures concern the routines and their respective organizational understanding. Thereby, I explore the different sub-systems from which a paradox emerges in a particular pluralistic organization.

The second research question on how latency is accomplished by handling the paradox within a pluralistic organization attends to the enacted solution of the paradox. The theoretical assumption of the paradox lens implies that an organization enacts a solution to the paradox in such a way that the paradox becomes latent prior to its salience. Drawing on routine dynamics, I search for a coordinating routine that relates the different meaning structures in such a way that their opposition becomes latent.

I approach the *third research question on how to embed paradoxical solutions* by focusing on reflection. The previous analysis shows the separation of those generating and proposing paradoxical solutions from those who are supposed to enact them. Routine dynamics helps to overcome this separation by extending reflection to both groups of organizational members. Figure 2-6 provides a summary:

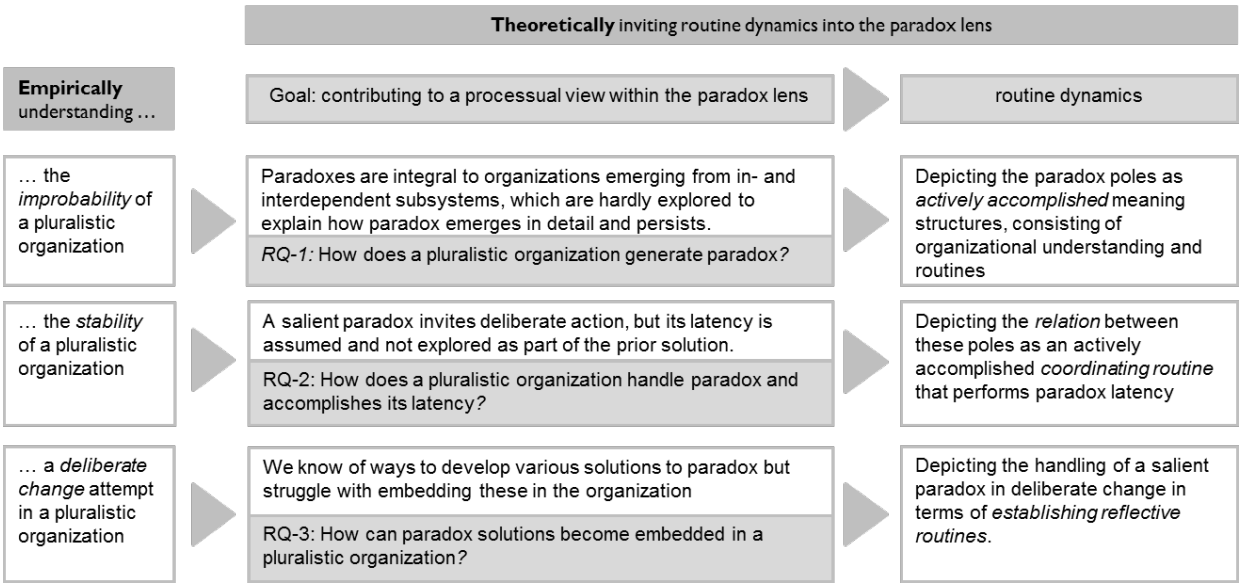


Figure 2-6: Research interests, research questions, and routine dynamics

Investigating these questions addresses my empirical research interests. I describe the observed improbability of a pluralistic organization in terms of a paradox. Attending to the prior solution that relates the paradox poles offers a path to illuminate paradox latency and to explain how a pluralistic accomplishes stability. Reflection offers a perspective to engage with deliberately changing a pluralistic organization when the change involves embedding paradox solutions.

By exploring these research questions, I aim to strengthen a processual perspective within the paradox lens. I pursue this goal using routine dynamics because it also assumes self-referentiality. Whereas a paradox lens tends to highlight the deliberate handling of observed persisting contradictions, routine dynamics emphasizes the situative and local enactment of an organization as an ongoing accomplishment. In both cases, reflection becomes essential in order to sustain and advance an organization.

3 Observing pluralistic organizations

Anything said is said by an observer (Maturana & Varela, 1980: 8)

Research elaborates on how and why a phenomenon operates. In our research we are interested in how and why a hospital organizes and manages itself in the way that it does. Exploring this research interest can offer alternative understandings and explanations to the organization which our research partners of the hospital and research colleagues in academia may find helpful for their respective purposes.

I assume research to be reflective because it generates its own blind spots due to the following reasoning: Research is a second-order observation and investigates an organization, a change initiative, or other topic located on a level of first-order observation (Luhmann, 1990a; see also section 3.2.3). Because an observation is an operation of distinguishing and indicating it cannot use a distinction and observe it simultaneously. Observing an employed distinction requires another distinction to observe it. Therefore, observation systematically produces its own blind spot, which is the employed distinction (von Foerster, 1994). While research aims to illuminate empirical blind spots, research produces its own blind spots (Fuchs, 1988; Knudsen, 2011). Blind spots call for a reflective approach to studying organizations in general (Alvesson & Sköldberg, 2000; Tuckermann & Rüegg-Stürm, 2010; Weick, 1999) and to elaborate on the following five aspects in particular (see Tuckermann, 2013a):

1. Explicating the research approach and the analytic framework;
2. Describing the research setting in its specific context and how the researchers engage in it to avoid systematic risks of longitudinal research;
3. Clarifying how the researcher engaged with the empirical phenomenon over time to generate the data in association with the research questions;
4. Depicting the process of analyzing the generated data in iteration with the academic literature;
5. Elaborating on the boundary conditions and systematic limitations of this research to provide the reader with the scope of research prior to engaging with the results.

Researching means to reconstruct the observed empirical practice by employing its own distinctions (Vogd, 2009; Willke, 1994). These distinctions draw on the academic literature to which the research refers and contributes. Therefore, research cannot provide a better, more comprehensive or more realistic view of reality, but it can lead to an alternative view that offers both scholarly and practically relevant explanations in the eyes of these audiences (Pettigrew et al., 2001; Tuckermann & Rüegg-Stürm, 2010).

3.1 Patterns, mechanisms, and analytic framework

This research adopts a process perspective to understand how a pluralistic organization like a hospital enacts itself as an organization. In line with this empirical concern, the research applies theories to a pluralistic setting and thereby questions them (Alvesson & Sandberg, 2013). It aims to elaborate (Lee et al., 1999) on a processual perspective within the paradox lens by drawing on routine dynamics (chapter 2).

A process perspective resonates with pluralistic organizations. Process studies problematize stability (Langley & Tsoukas, 2010) by assuming that organizations are temporal fixations in a world of flux (Hernes, 2008) and therefore active accomplishments (Feldman, 2000). This perspective thus differs from an entitative ontology and from variance theories (Langley, 1999; van de Ven & Poole, 2005). Phrased in observational terms, a process view embarks on a distinction that indicates stability as worth explaining before turning to how it changes (Tsoukas & Chia, 2002). Accordingly, my research questions address the improbability and the accomplished stability before turning to the deliberate change of a pluralistic organization.

3.1.1 Patterns and mechanisms to theorize in process studies

Theorizing within a process view distinguishes between at least two components (Langley, 2009): First, process research aims to depict patterns extracted from events unfolding over time. These patterns and second, are explained by an underlying mechanism. Patterns are repetitive events, activities or communications that become recognizable because of their repetition and because of their reference to a certain task or topic (Feldman & Pentland, 2003; Langley & Tsoukas, 2010). Thereby, patterns depict how events unfold over time. My empirical chapters contain such patterns to describe the

differences and similarities that point to the plurality of clinics and departments within a hospital in chapter 4; to identify the pattern of pursuing organization wide issues within this plurality in chapter 5, and to elaborate on the pattern of deliberately accomplishing change within one department in chapter 6.

Second, mechanisms are means to explain the observed patterns that serve as a sensitizing device and draw on theories (Langley & Tsoukas, 2010). As described above (section 2.1.3), I use self-referentiality as a sensitizing device because it is integral to paradoxes and to routine dynamics. Self-reference means relations of mutual constitution and duality thereby evoking a circular causality instead of a linear one (Kaufman, 1996).

In chapter 4, self-reference helps to explain how the clinics and departments reproduce themselves. These sub-systems express the plurality of the studied organization and evoke a paradox. In chapter 5, I attend to the relationship between the sub-systems that is enacted as a routine that accomplishes paradox latency. In chapter 6, self-referentiality provides the mechanism to explain the dynamic process of deliberately changing the nursing department by focusing on the establishment of reflective routines.

3.1.2 The analytic framework: paradox, meaning structure, and routines

The analytic framework specifies what is observed and results from my empirical interest and from engaging with the literature (Tuckermann, 2013a). The exploratory analysis to understand how and why hospitals organize and manage themselves in the way they do resulted in my three empirical research interests. The data analysis involved several iterations with different literature and the choice for works on routines and paradoxes. The analytic framework includes paradox and meaning structures, which distinguishes organizational understanding and routines (see section 2.2.1.3, p. 36f):

First, a paradox contains two (or more) poles that relate to another in a mutually constitutive albeit contradicting way. In my research, the poles of the paradox are the different clinics and departments that point out the plurality within a hospital and trigger the need for integration with regards to organization-wide issues (Jarzabkowski et al., 2013; Lawrence & Lorsch, 1967; Smith & Lewis, 2011).

Second, I use *meaning structure* to depict the different subsystems. Inspired by Hernes (2014: 111) meaning structure combines routines and organizational understanding as in Figure 3-1:

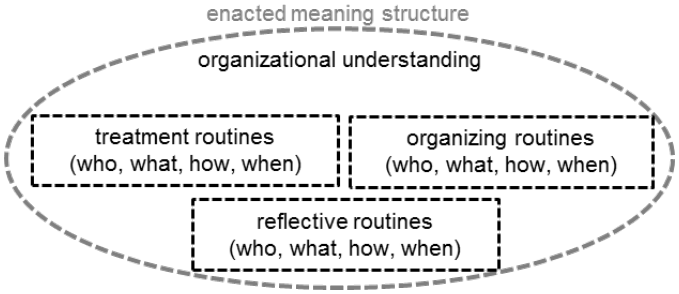


Figure 3-1: Meaning structure: organizational understanding and routines

Figure 3-1 displays that a meaning structure is a meaningful whole that is enacted and reenacted by the (non-) routinely operating actors and thereby manifests as the organization. In order to make use of this understanding, I differentiate routines from organizational understanding that relate in a self-referential way (Rerup & Feldman, 2011). *Organizational understanding* (Feldman, 2003) is similar to organizational schema (Balogun & Johnson, 2005) in that both point out "the shared assumptions that gives meaning to everyday experience and guide how organizational members think and act" (Rerup & Feldman, 2011: 578). The difference is that the organizational understanding in meaning structure notes that routines and organizational understanding relate in a mutually constituting way (Howard-Grenville, 2005; Barley, 1986; Stiles et al., 2015). Members draw on their organizational understanding to make sense of routines, and routines enact the organizational understanding (Feldman, 2003; Rerup & Feldman, 2011). In other words, "actors operate within and upon meaning structures" (Hernes, 2014: 111).

Routines are repetitive recognizable patterns of actions or communication that involve several actors (Feldman & Pentland, 2003). To depict the pluralistic setting of a hospital, I distinguish routines into the central treatment routines, the peripheral administrative ones, and reflective routines:

- *Central routines* are those "at the heart of a group's work" and "potentially affect how, and potentially how well, a group performs its primary task" (Gersick & Hackman, 1990: 91). In pluralistic organizations, the treatment routines are the central ones (Denis et al., 2007b; Jarzabkowski & Fenton, 2006; Rüegg-Stürm et

al., 2015; Schedler & Rüegg-Stürm, 2014). Treatment routines are central to a particular profession or discipline and the self-understanding of its members, such as doctors, nurses, or therapists (Edmondson et al., 2001; Glouberman & Mintzberg, 2001a; Kellogg, 2011; Vogd, 2004).

- *Peripheral routines* are those the actors often consider less relevant to the core task but may affect the efficiency of the group's work (Gersick & Hackman, 1990: 91). In a hospital, peripheral routines like those on budgeting, hiring, documenting or man-power planning provide important pre-conditions and resources for the treatment routines (Glouberman & Mintzberg, 2001a; Iedema et al., 2003; Llewellyn, 2001; Mueller, Sillince, Harvey, & Howorth, 2004).

- A third type is *reflective routines*, such as problem-solving, review-reflection (Adler et al., 1999), or learning routines (Bresman, 2013). Their task is to adapt central or peripheral routines. In hospitals, scholars report routines geared to continuously improve clinical practice (Iedema & Carroll, 2011), to reflect while introducing a new treatment regime (Edmondson et al., 2001), or to train and to maintain the scientific standards of a medical discipline (Kellogg, 2011).

Finally, in order to detect the similarities and differences between the investigated meaning structures, I use the following analytical categories of a routine (Feldman & Rafaeli, 2002: 310ff.): *what* is performed (task), *who* is involved (actors), *how* it is performed (steps), and *when* is the performance of a routine triggered (trigger). The categories of who becomes involved on what, how, and when are sufficiently intuitive to guide the data analysis. They are abstract enough to avoid pre-conceptualizing a routine (Chia & MacKay, 2007) and help to depict the "ways of acting" (Jay, 2013: 140).

This analytic framework of paradox and of meaning structure composed by organizational understanding and routines guides the analysis of the generated data that are the topic of the section on the research design.

3.2 Research design of longitudinal case studies

The research design of case studies (Yin, 1994) corresponds to the exploratory research questions and to the studies associated with routine dynamics and paradoxes. I first describe the empirical setting of the hospital, the investigated change initiatives, and the overview of the hospital integration initiative, which is the main focus of the chapters 4 to 6. The second section attends to the role of the researchers and includes the handling of three systematic risks.

3.2.1 The research setting of Laho and Reho and their integration

Pluralistic organizations provide an excellent research setting for process research because they problematize stability (Kraatz & Block, 2008). The presence of different world views, interests, and ways of acting makes stability a permanent achievement to avoid disintegration (Denis et al., 2001; Glouberman & Mintzberg, 2001a). Therefore, pluralistic settings provide an ideal setting for process research (Denis et al., 2007b).

Research in paradox and routine literatures emphasize the significance of specific contexts. My research takes place in a single setting with the fictional name of Laho. Laho is a leading regional hospital located in a state (cantonal) capital with 70.000 citizens in Eastern Switzerland. Laho is a pluralistic organization of knowledge-intensive work processes with relatively autonomous actors who pursue diverse strategic interests, resulting in ambiguous power relations (Denis et al., 2007b). With its five medical departments that harbor 32 clinics, and with administrative departments and nursing, Laho combines divergent perspectives (Ericson, 2001). The executive board of this public hospital reports to the board of directors which reports to the Canton's health department.

Figure 3-2 shows that Laho's executive board consists of the rotating heads of five clinical departments (here: Caitlin, Torsten, Pablo, Sebastian) as well as permanent members who are the director of nursing (Nada), the head of the infrastructure (Gabriel), the head of finances (Robin), the head of interdisciplinary medical services (Damian), and since 2003 the CEO of Reho (Martin). Hank, the CEO of Laho presides over the executive board, and the president of the board of directors (Gustav) regularly visits the executive board meetings and the bi-annual away-days.

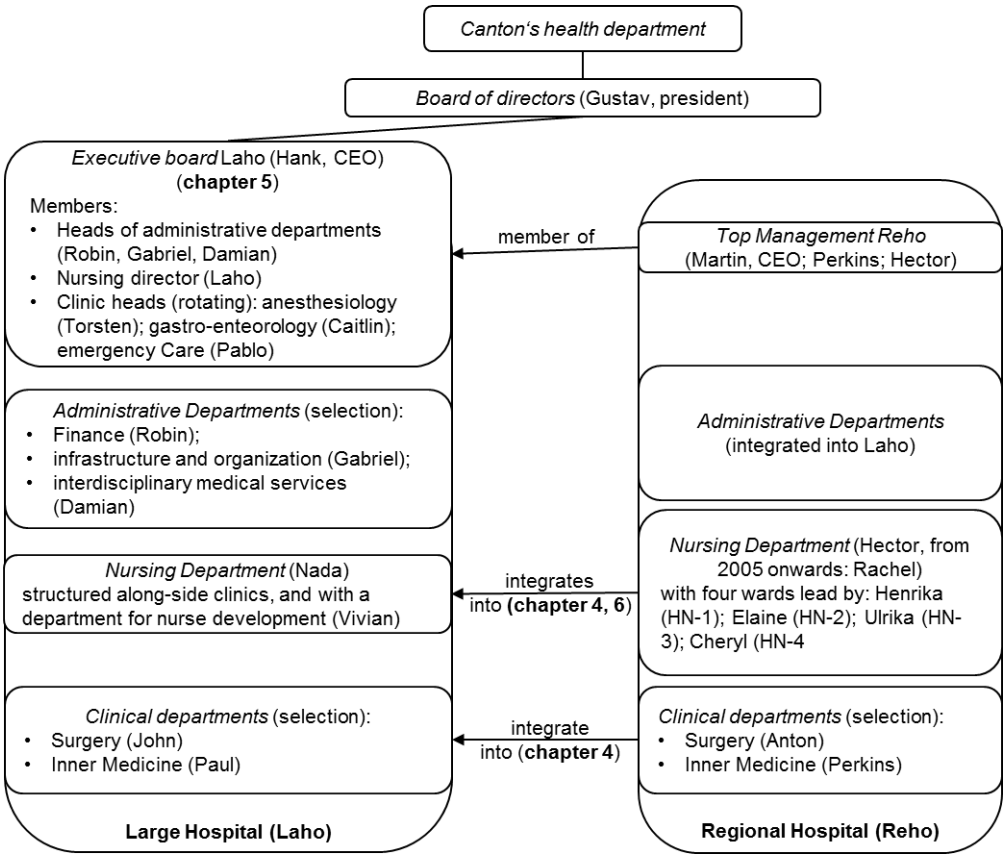


Figure 3-2: Organizational structure of Laho with names and chapters

Laho is subject to demands of politics, medicines, nursing, and management. Laho addresses the different demands of these perspectives and is no exception in looming misunderstandings, contradictions, and tensions. These emerge with a changing environment that has been and is still integral to the Swiss health sector. During the decade before the study, Switzerland had prepared to introduce a different financing scheme.[11] The different cantons (states) had conducted several attempts to reduce the costs of health care provision. Laho is no exception to other hospitals in which change initiatives have borne mixed results of successes and failures (Ericson, 2001; Lozeau et al., 2002; McNulty & Ferlie, 2004).

We entered Laho through Gustav. He approached us in fall 2003 when he faced challenges with the executive board to devise an overall strategy for the hospital region that consists of Laho and Reho: *"When we [board of directors] came, we were not embraced with open arms. The clinicians had not wished our presence."* After several preparatory meetings, we could engage with the executive board of Laho in March 2004. The executive board offered several change initiatives to accompany. One was the

[11] In 2012, the Diagnosis Related Groups (DRG) of financing hospitals according to patient treatments replaced the previous compensation of the conducted activities with the aim of enhancing efficiency in health care provision.

integration of Reho into Laho hospitals in combination with defining the hospital strategy and with a particular focus on the nursing department. A second one was the introduction of a new surgical regime by the clinic for surgery. In 2007, we could accompany the initiative to implement restricted working hours for assistant doctors throughout the clinics, and the evolving interdisciplinary center for palliative care in 2008. Table 3-1 provides an overview on these initiatives:

Initiative	Topic	Units-of-analysis	Field research	Case Studies
Integration Reho into Laho including developing a strategy	hospital integration and develop a strategic positioning of the newly formed hospital for the public owner	executive board, nursing, surgery and inner medicine	2004-2007	Tuckermann (2007)
Introducing Fast Track Surgery	introducing a new surgical regime to enhance recovery and to prepare for the new financing scheme in Swiss healthcare	surgery, nursing, anesthesiology, executive board of the hospital	2004-2006	Bucher & Tuckermann (2009); Bucher (2011)
Centre for palliative Care	implementing palliative care, an interdisciplinary center to introduce a new hospital service	executive board, palliative care, oncology clinic, nursing	2008	Sauter (2010)
Employment law Case	implementing the new employment law: restricting work hours for medical doctors and aiming to enhance optimized processes in clinics	executive board, all clinical department and nursing	2004-2007	Merz (2010)

Table 3-1: Case studies at Laho

These initiatives provided a profound and longitudinal access to the different clinics and departments in real-time and over a period of five years. They are a promising way to investigate my research interest. First, what is taken for granted often becomes contested and therefore salient for observation (Langley & Denis, 2006), which is also the case for paradoxes (Smith & Lewis, 2011). Second, we were able to both trace the initiatives backwards and follow them forward as they unfolded (Langley & Tsoukas, 2010), thus observing patterns of how change unfolded in relation to the ongoing daily practice within the hospital (Langley & Denis, 2006). Third, the access to different clinics and departments helped us to engage with this organization's plurality. Fourth, our engagement across the different levels of hierarchy ranging from the executive board to the wards with their treating patients enabled us to incorporate the different perspectives of organizational members in their specific work contexts (Denis et al., 2001).

In this text, I mainly report on the integration process of Reho into Laho over a period of nine years. Figure 3-3 shows the integration process followed by a description of the unfolding events over time:

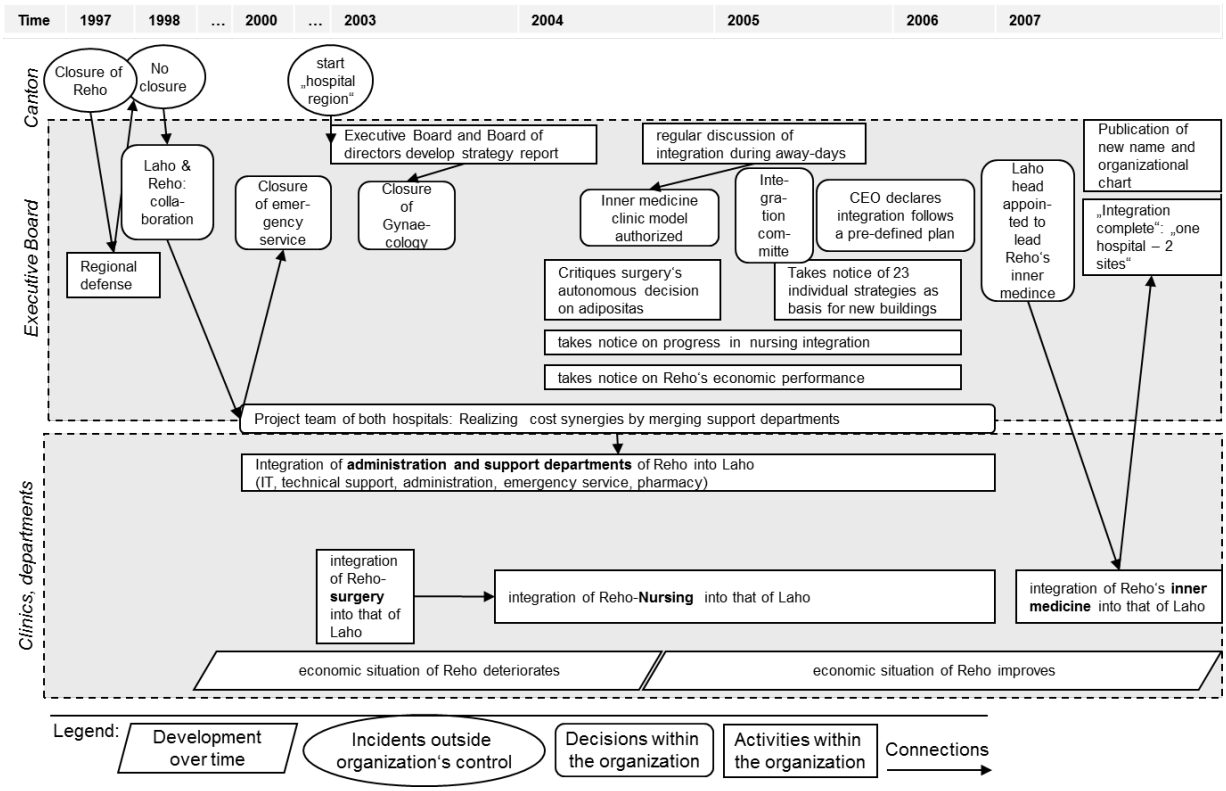


Figure 3-3: The hospital integration of Laho and Reho (1997-2008)

The hospital integration starts around November, 1997. The cantonal government as the public owner of the hospitals announces to close Reho to reduce costs. After a period of demonstrations and local media coverage the cantonal government withdraws the decision in May 1998. The CEOs of Reo and Laho, Martin and Hank, decide to cooperate more closely, after agreeing on principles for their cooperation. Martin and Hank launch a project team consisting of equal numbers of administrative, nursing, and medical representatives of Reho and Laho. The project team suggests integrating Reho's administrative departments into those at Laho. In 2000, the departments of technical support and IT are closed at Reho and operated from Laho. Two years later, the same happens with the emergency care unit arousing critique: "Without emergency care, we are not a primary care hospital anymore" (Martin). Due to cost pressure, Reho accepts. Likewise, the executive board decides to close the gynecology department by the end of 2003; this decision leads to both internal resistance and an attempt to mobilize the local citizens, as in 1998.

In spring 2002, Laho's surgery faces excess capacity while that of Reho struggles with a lack of capacity of their surgery clinic. Reho's nursing director (Hector) and Laho's head surgeon (John) agree to rent surgery rooms to Laho. With Reho's head surgeon leaving the hospital a few months later, John proposes to take over Reho's surgery. Within a period of six months, Reho's surgery adapts to the standard operating procedure of Laho. Laho's head of surgery (John) declares the integration successful in fall 2002, using the slogan: "One clinic – two sites". This indicates that Reho's surgery now operates similar to that of Laho and is run by one of Laho's leading surgeons.

On January 1st, 2003, the canton government announces the hospital region of Reho and Laho. In spring, 2003, John complains to Nada, Laho's nursing director, about Reho's surgical nurses. John's critique concerns nursing standards, ways of working, and levels of qualification that do not fulfill the surgeons' expectations. After an analysis of the surgical wards and a report on areas for improvement, Nada deploys Rachel as a change agent for Reho. In summer, 2004, Rachel is positioned along-side Reho's nursing director (Hector). Rachel is responsible for all wards at Reho and is supposed to adapt Reho's caring and organizing practice to that of Laho. Rachel involves all employees into the integration process. The initiative ends in December 2006.

In fall 2004, Laho's inner medicine begins to approach the integration of Reho's department by preparing an initial concept of the integrated clinics. From summer, 2005 onwards, Laho's head internist Paul takes part in a so-called integration committee, a monthly meeting of clinic heads of inner medicine, anesthesiology and orthopedics of both hospitals. The committee aims to discuss ways to integrate each clinic and to coordinate among each other. Laho's head internist discusses the meetings internally with his leading internists during their regular meetings. They decide to "wait and see" what emerges (Paul). They also consider it important to reach consensus with the Reho's head internist about the integration. He retires in 2007, and Laho's internists meet with their Reho colleagues, adapt their work procedures, hold joint meetings, and install a mutual rotation system for internists to work at the respective other site.

In December 2007, the executive board publishes the organizational chart of the hospital region. Reho is granted the status of one of the five large departments and uses the name of Laho that labels the hospital region. During the executive board's annual retreats, the

hospital integration is a regular agenda topic, at least during our field phase of 2004 until 2006. Here, the board members discuss past year's achievements and developments in the different clinics and departments as well as the overall hospital strategy. With inner medicine integrated in 2007, the executive board of the hospital region declares "integration completed". The yearly report adopts the surgeon's slogan of "One clinic – two sites" to describe the overall idea.

Chapter 4 contains the report of how the clinics of surgery and inner medicine and the nursing department conducted their integration initiatives. These are explained by their respective meaning structures. Chapter 5 emphasizes the discussions in the executive board that illustrate how the issue of integrating the hospitals was moved forward situatively when attending to potential conflictual topics. These situations reveal the informal routine of "bilateralism" which we also detected in the other case studies. Chapter 6 explores in depth the integration of the nursing department. My close attending to this process over two years provides data to illuminate on how reflective routines became established as both a medium and as an outcome of this initiative.

3.2.2 The role of the researchers and handling three systematic risks

Our longitudinal and direct research enables a profound engagement with different research partners within the hospital. These engagements yield in-depth insights into the studied hospital from a wide variety of perspectives. Our research partners expected us to report on the challenges and their handling during the change initiatives. Our role was that of emphatic non-participant observers (Langley, 2009: 421) who offered regular feedback to the different research partners but without providing advice as in action researchers (Reason & Bradbury, 2001). We framed our observations as different but not better alternatives following the insight that any observation is subject to its own blind spots. Due to our role, we reflected in detail on the dynamic research process throughout and after the field phase (Tuckermann, 2013a; Tuckermann & Rüegg-Stürm, 2010).

Adopting the role of an empathetic non-participant observer bears at least the three risks (Langley, 2009: 421) of reactivity, going native, and political alignment.

The risk of reactivity points out that the research activities change that what goes on in the organization. Longitudinal direct research is reciprocal. Researchers and practitioners

relate over a period of time (Dutton & Dukerich, 2006). In this relationship, not only researchers observe their partner, but organizational members also observe the researchers (Barley, 1990). However, over time, the research partners took less and less notice of our attendance in meetings or on the wards (Tuckermann, 2013a). After all, their demanding work of treating patients absorbs their attention significantly (Barley, 1990). In comparison, we were more prominent during the feedback workshops (Iedema, Degeling, White, & Braithwaite, 2004). Here, reactivity occurred in the sense that the research partners adopted certain phrases we used to label our observations. Inner medicine for example used “iterative-cyclical treatment process” to depict their core activity of diagnosing. Beyond the reactivity of language, our research partners were autonomous professional who decide for themselves if and what they concluded from our feedback (Tuckermann, 2013a). These choices themselves provided us with further insights into their meaning structures (chapter 4), how they engaged pursuing organization-wide initiatives (chapter 5), or how they conducted the integration of the nursing department (chapter 6).

The risk of going native by losing the researcher’s perspective occurs when researchers gradually adopt the practitioners’ perspective. Avoiding the risk involves several means. First, working with an abstract approach like that of social systems theory (Luhmann, 2000) helps to guide observations and analysis in keeping the distance with the researched organization. Second, a reflective research approach of explicating underlying assumptions and reflecting on them assists in considering the evolvement of the roles and positioning of researchers in relation to their research partners (Tuckermann, 2013a). Third, in our research practice, we work in pairs to incorporate different perspectives. Each researcher keeps a field journal that helps to track the evolving understandings and perspectives of the researchers. Furthermore, we established reflective settings for our own research during the field phase and the following analysis period. These reflective settings systematically incorporated the different levels in generating and interpreting data. During the field phase, each interview concluded with a reflective question to invite our interview partner to reflect on the interview. After each field contact, the research team engaged in a preliminary analysis to capture emerging insights in relation to the generated data. Here, the team identified open issues and further questions. We also discussed our observations and the case narratives with the research partners in feedback workshops. While analyzing the

data and generating the case narratives, the researchers continuously engaged in joint discussions about the emerging case. Beyond the immediate research team, we regularly discussed our academic paper drafts in a wider team of researchers that were not involved with hospitals, thereby using further perspectives on literature and empirical settings as points of reflection. The continuous engagement with the academic community on conferences fulfilled the same purpose on relating results, interpretations, and theories.

The risk of political alignment requires measures to refrain from taking sides within the researched organization. In our research, we aimed to enact a neutral position relative to our research partners that was conscious of their diverse perspectives and interests. First, our field relation aimed to adopt elements of appreciative inquiry (van der Haar & Hosking, 2004). We pragmatically assumed that our research partners worked with the intention to provide good patient care. This assumption implied to search for plausible reasons and explanations of any observed actions, decisions, or communications. Second, our approach with several case studies brought us in contact with different actors within the organization, involving a wide range of clinical, nursing, and administrative departments, as well as different levels of hierarchy, ranging from the shop floor to the board of directors. Appreciating their different work situations and perspectives helped to maintain a neutral positioning that focused not on any view as the right one but rather on their dynamic interplay (Tuckermann, 2013a). To this end, the paradoxical approach adopted here with its appreciation of different meaning structures (chapter 4) and the goal to understand how different meaning structures relate in pursuing organization-wide tasks (chapter 5) or within a specific change initiative (chapter 6) mirror this positioning as neutral observers.

Adopting the role as an empathetic nonparticipant observer enabled profound and prolonged access to the research site. This role expresses a collaborative relationship with our research partners through which we addressed their expectation while avoiding the systematic risks that are involved throughout such periods of time.

3.3 Generating the data through several change initiatives

Our approach allowed us to engage closely with Laho over several years and generated a profound data base. The data results from four different sources (observations, interviews, documents, and feedback workshops), summarized in the Table 3-2:

Case	Observations	Interviews	Documents	Feedback-Workshops
Hospital integration and strategy development	67	71	69	20
Introducing a new surgical treatment (Fast Track Surgery)	17	29	50	13
Implementing the Employment Law	70	67	146	5
Center for palliative care	5	14	--	6
Sum (data base)	**159**	**181**	**265**	**44**

Table 3-2: Data base in reference to the case studies at Laho

Within our two-person research teams, I participated directly and ongoing in the cases of the hospital and nursing integration as well as Fast Track Surgery. Within the cases of the employment law and the Centre for Palliative Care, I accompanied my colleagues in several but not all field contacts and mainly engaged in analyzing the data and in the feedback workshops. In each case study, we kept a journal during the field phase, which I also used during the analyzing period, thereby enabling to trace back emerging insights. Besides, there we documented numerous informal conversations with the practitioners.

3.3.1 Observations, interviews, and archival data

Observations are an essential means to engage with the research setting regarding patient treatment, organizational and managerial topics. Observations also complement interviews. They generate descriptions by the researcher and therefore capture aspects that may otherwise remain dormant in interviews (Alvesson, 2003).

The data set includes 159 observations, in which I participated in 85. The other observations took place in the initiatives “Implementing the employment law” and “Center for palliative care”. The observation sites were both in the clinics of inner medicine and of surgery, the nursing department, and the executive board.

In the executive board, we were present in both regular board meetings and board away-days, which lasted for two days each. Furthermore, we participated in the project meetings of the "employment law" initiative. This project team consisted of several executive board members and middle rank representatives of clinics and departments. Furthermore, we participated in meetings on advancing the unit of emergency care with a similar membership. In these three settings, we observed the professionals' interaction on different topics. Within the clinics our observation ranged across the hierarchy from meetings on particular patients up to clinic leadership. Furthermore, we took part in the morning shifts of the clinics for surgery and inner medicine at both hospitals for a week each. Therefore, we had four weeks of prolonged ward visits in the wards to gain insights on the doctors' and nurses' daily work treating patients and organizing the wards. In addition, we followed doctors of inner medicine with three researchers for two days each in order to better understand their daily work. In comparison to surgeons who are bound more to a physical location, internists move around different clinics. Within the nursing department and besides our ethnographic visits we observed ward meetings and meetings of nurse leadership at Reho. In the latter, I was present regularly every fortnight during the field phase as a non-participant observer.

All observations were documented in detailed field notes and transformed into memos shortly thereafter. The resulting text-files included context information on the room and the sitting order, the participants, the content on the topics, the unfolding practitioners' conversations, and the researcher's interpretations. For reasons of patient and employee privacy, we did not record any meeting (Miller & Luft, 1997).

The second data source of semi structured interviews provide the possibility to engage with the perspective of our research partners on the different change initiatives, on the hospital, and on their work experience. Therefore, the interviews complement our emerging insights gathered in observations.

The data set includes in total 181 semi-structured interviews of one to two hours, of which I participated in 125 being absent from several interviews of the initiatives "Implementing the employment law" and "Center for Palliative Care". The interviews regarded the interviewees' understanding of the change initiative in their work and organizational context. With selected key informants of inner medicine, surgery, nursing and the executive board, we repeated interviews between two and six times to capture

the evolving perceptions on the hospital integration, the integration of the nursing department, and on Fast Track Surgery (see also Jarzabkowski et al., 2012).

The interview population was defined in reference to the change initiative guided by a contextualist framework (Pettigrew et al., 2001) to gather data on the content of the initiative, on the sequence of unfolding events, and on the internal and external context. Throughout this focus, we interviewed organizational members on all hierarchical levels of the medical disciplines, of nursing and of administration.

Each interview followed a similar structure. We started out biographically and explored important topics throughout the interviewee's career at the hospital before engaging with the particular change initiative (Tuckermann, 2013a). Then we asked the interview partner to recount the emerging history of the change initiative, its current state, and his or her future expectations. We also invited the interviewee to explain how and why the course of the initiative evolved in the way that it did. Each interview concluded with the reflective question of what our interview partner took away from the interview. This question invited the interview partner to more broadly elaborate on his or her perspective on the hospital and the issues brought up during the interview. After each interview, the researchers reflected upon the encounter for an initial interpretation following the rule that each insight required a clear reference to the generated data. This initial interpretation supported to explicate the emerging insights and to generate further questions. All but one interview were recorded and transcribed for further analysis.

The third data source contains 265 pieces of *archival material* ranging from internal conception papers and presentations, meeting agendas, and minutes, mail and email correspondence to publicly available data of annual reports and media coverage. Within each case study, we sorted the archival data to each topic first in temporal order of appearance to track the sequence of events both internally and with reference to the respective context of that initiative. Further on, we used the archival material to triangulate its content with that of the other data sources.

3.3.2 Feedback workshops as second-order observation data

The fourth data source is *feedback workshops.* Usually, they serve as means for member validation rather than a source of data like the previous three sources (Miles & Huberman, 2005). From an observational standpoint, feedback workshops are an interaction between researcher and research partners on a second-order level. The researchers reported their observations and interpretations, that invited the research partners to reflect on these reflections (Iedema et al., 2004). As a data source feedback workshops help to validate and further advance the empirically generated insights (Schumacher, 2015).

We offered 44 feedback workshops. Each of them followed an inside-out rule in that we engaged first with those research partners who we observed and interviewed directly before approaching their superiors given the consent of their subordinates. The feedback workshops contained our emerging understanding of the respective case dynamic combined with our understanding of the specific context. The latter included the understanding of daily work within the respective department or clinic (Pettigrew et al., 2001). Usually, three researchers conducted the feedback workshops to distinguish the facilitation from the content and to ensure a detailed documentation of the unfolding conversation. While presenting our insights, we engaged in conversations guided by two questions: “Did we understand you correctly?” and “What do you make of these observations?” The first question was geared to check the correctness of data and to clarify comprehension in general. The second question invited the research partners to reflect on our observations. This part of the conversation not only validated our findings but generated additional data through the group’s collective reflection .

Overall, the research partners allowed us to freely approach organizational members for interviews, supported us in coordinating observations, granted us access to internal and external documents, and participated actively and openly in the feedback workshops. We were thereby granted a prolonged and profound engagement with the studied organization. The field research generated a substantial database that mirrors the plurality of diverse perspectives and hierarchical levels throughout the organization and captures the temporal evolvement of different topics within Laho.

3.4 Analyzing the data in iterations with different literatures

The analysis involved several methods for theorizing from process data (Langley, 1999):

First, each initiative resulted in a single narrative of the unfolding events in their specific context following a contextualist framework (Pettigrew et al., 2001). To provide further guidance of the often complex data, the narratives of Bucher & Tuckermann (2008), Merz (2010), and Tuckermann (2007) employed visual mapping (Langley & Truax, 1994) in order to depict the trajectories of the change process (Stensaker & Langley, 2010). For in-case comparisons, we divided each narrative analytically into episodes for temporal bracketing (Langley, 1999). The distinction of the episodes followed points in time that our research partners considered critical (Oliver & Roos, 2003). In this phase of generating a single case narrative the respective first author coded the data and triangulated the different sources of interviews, observations, and documents systematically (Miles & Huberman, 1994). In my case of the hospital integration, I first developed a time table of events mainly drawing on documents. It followed the coding of the interview data and that of my field diary to these events to capture the evolving different meanings. Third, I included the observational data to grasp the internal context of the organizational members' daily work. Within the other cases my role was to critically reflect on my colleagues' analysis regularly by engaging with the raw data and my colleagues' interpretations. Dr. Silke Bucher did the same in my case. Our joint interest in hospital change and the common background in social systems theory offered a common base for the continuous conversations. The different empirical cases and our separate research questions helped to maintain our differences.

Second, several iterations between literature and data led to the current text. The exploratory general interest (Alvesson & Sandberg, 2013) into understanding hospital organization and management from a process perspective means to attend to different literatures. These visits to the literature triggered further data analyses. Throughout the iterations, the initial research interest differentiated into the three topics reported in chapter 1. They correspond with the research questions that relate to the selected bodies of paradox and routine dynamics literature.

Chapter 4 reports on the different meaning structures of surgery, inner medicine, and nursing. They express the plurality of a hospital in order to detect the similarities and differences that give rise to in the paradoxical character of these organizations. Making use of meaning structures emerged as follows. For a conference paper in 2005 (Tuckermann, Bucher, & Von Arx, 2005), the authors experimented with a discursive approach (Grant & Iedema, 2005) to explain the dynamics of introducing the new surgical regime. Here, we focused on patterns that relate surgery and nursing as different discourses. With our data being in Swiss German, transcribed in High German and translated to English, the language barrier made an in-depth analysis of discourses risky. In my doctoral thesis (Tuckermann, 2007), the understandings of surgery, nursing, inner medicine, and administration provided part of the internal context from which I reconstructed the integration initiative within the nursing department as a cyclical pattern of different paradoxes. In 2012, this background moved to the front stage (Tuckermann, Lai, & Mitterlechner, 2012), which meant that it was necessary to reanalyze the data. I coded the data along the social systems theoretical concept of decision-premise (Luhmann, 2000). Decision-premises are the mutually held expectations of who decides on what, when, and how. This approach helped to specify the categories of depicting a clinic or department. But, this focus prioritized the structural dimension over the performing of decisions. Addressing the latter, Carola Wolf and I (Tuckermann & Wolf, 2014) transferred decision-premise to depict the ostensive dimensions of routines and revisited the data for further analysis. The routine dynamics literature helped to depict and differentiate between types (Adler et al., 1999; Bresman, 2013; Gersick & Hackman, 1990) of routines along the categories of who becomes involved into what issue, how, and when. Drawing particularly on Rerup & Feldman (2011), we used organizational schema and its association with different routines to provide a description of the nursing department at two points in time. However, the construct of organizational schema (Balogun & Johnson, 2005; Rerup & Feldman, 2011) evokes a cognitive bias and tends to suggest that the understanding is separate from practice (Hernes, 2014). Therefore, for the current text, I turned back to the similar notion of “organizational understanding” (Feldman, 2003) that self-referentially relates with routines as a meaning structure.

Chapter 5 follows the investigation of how the studied hospital enacts its stability given the plurality of its meaning structures that risks organizational disintegration. Addressing this risk as the paradox of differentiation and integration, chapter 5 elaborates on the

coordinating routine through which organization-wide issues are moved forward while achieving paradox latency that avoids paralysis (Ford & Backoff, 1988). The research focus on a coordinating routine emerged as follows. As part of the internal context of the contextualist research to my doctoral thesis (Tuckermann, 2007), the executive board was a periphery site for observation. At the same time, the executive board members reported their understanding of this setting as a non-decision-making body. How then did organization-wide issues move forward within this organization? In the interviews and the observations throughout the different change initiatives, the research partners labelled the pattern of moving organization-wide issues "bilateralism", which they often related to "garden thinking"; this label was used to depict the autonomy and diverse interests of different clinics and departments. Both labels allowed coding the data of the different change initiatives to extract different aspects of bilateralism as a pattern for organizational decision-making. After validating these insights with the executive board in a one-day workshop and while working on a book chapter (Rüegg-Stürm, Tuckermann, Bucher, Merz, & Von Arx, 2009), we found a similar pattern in a Swiss university hospital. More deeply engaging with organizational decision-making (Chia, 1994; Langley, Mintzberg, Pitcher, Posada, & Saint-Macary, 1995; March, 1991; Mintzberg & Waters, 1990), this academic discourse did not appear promising. Decision theories remain mainly on the level of individuals or groups and hardly address the enacted collective patterns of decisions. Furthermore, the literature does not adhere to the pluralistic context of hospitals for which a paradox perspective appears more promising. Rooting the empirical insights in social systems theory, I reanalyzed the data along dimensions of decision premises to present bilateralism in a conference paper (Tuckermann, Lai, Mitterlechner, & Rüegg-Stürm, 2013) as a means to handle the paradox of differentiation and integration. Turning from this view to routines complemented the performative dimension and required revisiting the data for further analysis. Given that bilateralism is an informal routine of private conversations, it is difficult to observe its performance directly. At the same time, by engaging in the recent developments of the paradox literature, a new insight emerged that bilateralism presents a collectively enacted paradox solution without being designed deliberately (Clegg et al., 2002). In relating the poles of differentiation and integration, bilateralism accomplishes paradox latency and therefore helps to explain our observations on the executive board and its members' accounts. For the current text, I therefore revisited the original data of

our observations on the executive board to detect the salience and latency of paradox that are reported in chapter 5.

Chapter 6 reports in detail the integration of Reho's nursing department into that of Laho. The focus on establishing reflective routines helps to explain the dynamics of the deliberate change initiative. This focus resulted as follows. The integration of nursing was the single case study of my doctoral thesis in 2007. Social systems theory (Luhmann, 2000) and the theory of change as an intervention system (Fuchs, 1999) helped to explain the unfolding events as a cyclical handling of paradoxes that transformed from one paradox to another (Beech et al., 2004; Hundsnes & Meyer, 2006). In 2008, I presented the communicative patterns that helped to work through the paradox of enacted and proposed organizational understanding. These communicative patterns remained at a generic state without relating them in detail to the organizational understandings. In 2011, I reanalyzed the data (Tuckermann, 2011) and focused on the relationship between the two poles to build on a relational view of paradoxes (Clegg et al., 2002). At this stage, the concept of awareness (Weick & Sutcliffe, 2006) helped to describe the relation between the poles as "organizational awareness". However, awareness associates rather with an attitude or mode of being than with capturing the process of how awareness emerges and becomes established as a collective achievement. To this end, routine literature and its recent discussion on routine emergence (Parmigiani & Howard-Grenville, 2011) offered a promising perspective as studies highlighted the importance of reflection both in performing (Feldman, 2000) and in altering routines (Feldman, 2003; Howard-Grenville, 2005; Rerup & Feldman, 2011). For a conference paper (Tuckermann & Wolf, 2014), we turned to reflection as routines that involved to reanalyze the data in terms of how reflective routines emerged within the nursing department. As this paper marginalized the paradox involved, the current text results from another iteration of inviting routine dynamics into the paradox literature.

Self-referentiality is the underlying mechanism (Langley, 2009; Langley & Tsoukas, 2010) to explain the patterns reported in the empirical chapters 4 to 6. Rooted in social systems theory (Luhmann, 1984, 2000), I noted the challenges of this German theory within the English speaking domain (Hernes & Bakken, 2003; Schoenenborn, 2011; Seidl & Becker, 2006). Relating social systems theory to other theoretical approaches helped me to clarify its potential as a process theory in general (Hernes, 2008) and its notion of self-referentiality as a duality of event and structure in particular (Luhmann,

2000). While concepts of duality gain increasing importance (Denis et al., 2001; Farjoun, 2010; Feldman & Orlikowski, 2011), they often draw on the duality as proposed by Giddens (1984). Tracing back duality in social systems theory provides a related alternative of second-order cybernetics (Maturana & Varela, 1980; von Foerster, 1984, 1994). Epistemologically, this approach embarks with the assumption that any insight is observer dependent (Jarzabkowski, Bednarek, & Le, 2014: 284, note 2). Observation, in its abstract definition as an operation of distinguishing and indicating (Spencer-Brown, 1969), is a self-referential process. The observational structures that guide observation and the event observed mutually constitute each other. American sociologist Barry Barnes (1983) calls this process of observing and creating reality "inductive bootstrapping". Likewise, Barbara Czarniawska (2008: 78) makes use of the metaphorical story by Münchhauen, the Baron of Liars, who claims to pull himself out of the mud by his own pigtail. Similarly, Linda Putnam (1986: 166) wonders "how organizations pull themselves out of the self-made quagmires by their own bootstraps". In comparison to structuration theory (Giddens, 1984), an observational framework does not restrict to the individual as both the mediator between action and structure and the explanatory fountain of action (Seidl & Becker, 2006). A second advantage of the observational framework is that it conceptualizes the research practice and the researched practice in the same terms (Tuckermann & Rüegg-Stürm, 2010).

These sections reported on the analytic process as a journey sorted along the three empirical chapters. They involved several iterations between different literatures and the data in order to better understand pluralistic organizations. Although the process involved several rounds of reanalyzing and coding the data, my report cannot illuminate entirely how my insights emerged. After all, "no analysis strategy will produce theory without an uncodifiable creative leap, however small" (Langley, 1999: 691).

3.5 Boundary conditions and validation of the empirical results

Any research is uncomprehensive (Hernes, 2008). Iterating between the empirical data and different theories involves selections as illustrated above. The following section summarizes the systematic limitations of each empirical chapter. These and further limitations provide boundary conditions that will be taken up as suggestions for future research in chapter 7.

Across all three empirical chapters, I aim to understand the ways of acting or organizing (Glouberman & Mintzberg, 2001a; Jay, 2013) by drawing on the views of the hospital members to depict in more detail how this pluralistic organization operates.

3.5.1 Boundary conditions of the empirical chapters

In *chapter 4*, my results report on the different meaning structures of surgery, inner medicine, and nursing with their organizational understandings, the meaning they give to patient treatment, to their clinical and departmental organization, and to their reflective routines. I elaborate in less detail on the repetitive and varying performance of specific patient treatment, organizing, and reflection routines. The results instead engage with the ostensive dimension in terms of who becomes involved, on what issues, and how. These results associate with the organizational understanding of the different clinics and the department in a mutually constitutive way. Thereby, I depict the specific perspective from which organizational members tend to observe and enact topics and initiatives like the integration of clinics, departments, or the hospital.

In *chapter 5*, the empirical research is on handling the organization-wide issue of the hospital integration. This issue is moved forward by a coordinating routine called "bilateralism" that labels the pattern of relating the different and contradictory meaning structures in the pluralistic setting of the studied hospital. The systematic challenge of researching this routine is its informal character. The label bilateralism indicates that agreements and commitment evolve in private conversations that are shielded from observation, even for members like Gustav, the directors' board's president: "With their high degree of inter-relations and with their continued high autonomy, a lot of issues go through the informal networks of personal relations between the clinic". Nevertheless, it qualifies as a routine for three reasons. First, interviews that are private conversational settings themselves reveal that the coordinating routine is known across the organization. Respondents of different clinics and departments openly reported its enactment within this organization. Second, the comparison with other case studies revealed the enactment of bilateralism. The way of initiating the new surgical regime within the hospital followed a similar pattern (Bucher & Tuckermann, 2009). In establishing the palliative care center, the involved middle managers struggled with the unobserved bilateral agreements of their superiors (Sauter, 2010). In addition, the employment law case exemplifies bilateralism in use (Merz, 2010). Third, we validated bilateralism and its

relation with the paradox of differentiation and integration by conducting a one-day workshop with the executive board. Its members confirmed: “These are the rules of the game around here” (Torsten, the head of anesthesiology). Likewise, Nada, the nursing director states: “Yes, it works like that. It works, with some pains and all, but we can handle that”. Therefore, the specific coordinating routine presents the way in which this hospital pursues organization wide topics.

The results *in chapter 6* focus on the meaning structures within a single department and on the emerging reflective routines. This focus on reflective routines and their emergence results from the analysis. It helps to explain how the deliberate change initiative moved forward so that it weaves into the ongoing routine performance (Langley & Denis, 2006). This focus is selective in that it attends less to the change of specific treatment or organizational routines. Focusing on a single routine would have obscured the role of reflective routines in my case as they extend to the entire department as both medium and outcome of the change. Although such a focus on specific routines may express this movement, it does not reflect that the organizational members attempted to alter several routines simultaneously and the organizational understanding.

3.5.2 Validating empirical results and explanations within Swiss health care

My exploratory research questions imply a case study approach (Yin, 1994). But generalizing from the single organizational setting is limited (Langley, 1999). Engaging in and analyzing several initiatives allows for specifity and accuracy. Moderate generalizability stems from that the process of unfolding events (van de Ven, 1992), and the situative enactment are central rather than the outcomes (Stiles et al., 2015: 86).

With our research partners within each case study, we regularly validated our findings through the feedback workshops. Furthermore, key informants read and confirmed the different case studies, which we discussed with them extensively. They accepted the analyses as a valid explanation to the respective topic of the change initiative.

Furthermore, we validated our results and explanations within the Swiss healthcare sector in different ways: Our research team has regularly published articles on organizing and managing hospitals in “Schweizerische Ärztezeitung” since 2007 (see appendix 8.3, p. 214). The journal is distributed to all Swiss medical doctors and

involves an editorial review process. These publications validate the empirical results because their readers actively comment in emails to the authors and in letters to the editors. Their responses were reassuring but also critical. Besides the “Schweizerische Ärztezeitung”, the results have been published in other journals (Tuckermann & Erk, 2015; Tuckermann & Rüegg-Stürm, 2012) as well as in book sections for a practitioner audience (Rüegg-Stürm et al., 2009; Tuckermann, 2013b, 2014). Furthermore, the results reported in chapters 4, 5 and 6 have been presented and discussed in a workshop with selected hospital CEOs and are used reassuringly in our executive education programs with health care professionals. These means of publishing and discussing the empirical research in different settings help to validate the empirical results beyond the specific case context.

3.6 Summary of the research topics in chapters 4-6

In this chapter, I elaborated on research as a second-order observation. As observation, research is a self-referential process like the empirical phenomena it observes. Each of them produces its own blind spots, so that the research practice is a reflective one. Therefore, I elaborated on the analytic framework of meaning structures and paradox; on the research design of a single setting drawing on different change initiatives; on my role as empathetic non-participant observer; on the means of generating and analyzing data; and on systematic limitations within this single setting.

The following three empirical chapters focus on the process of integrating Reho into Laho. First, they highlight the differences between surgery, inner medicine, and nursing as to how they pursued their integration (chapter 4). Second, in light of the salient paradox of differentiation and integration, the focus is on how the executive board handled unresolved and potentially conflictual issues. The results reveal a coordinating routine that unfolds the paradox and achieves latency (chapter 5). Third, chapter 6 deals with the integration of the Reho nursing into that of Laho. It illuminates the establishment of reflective routines by which two initially opposing meaning structures relate over time.

4 The paradox: Differentiation and integration

"Self-referentially operating systems cannot only avoid paradoxes …, but they also produce them continuously." (Dirk Baecker, in von Foerster, 1994: 21, my translation)

This chapter concerns my first research interest on how a pluralistic organization reproduces its improbability. A paradox lens helps to address the improbability by assuming that paradoxes are integral to organizations. Paradoxes emerge from the independence and inter-dependence of the different sub-systems or clinics and departments, respectively. A detailed exploration of these different sub-systems remains under researched within the literature. Insights on how a clinic or department enacts itself provide an important empirical background to the central assumption of the paradox lens. Such insights follow the argument that a paradox is enacted situatively and locally. This argument triggers the need to depict in detail the different perspectives actors draw on in their interpretations and observations. Hence, my research question is: How does a pluralistic organization generate a paradox?

For this research question, meaning structures help to explore the organizational understanding and the associated routines to depict different clinics or departments. The main goal is three-fold. First, I aim to specify the different meaning structures. Second, within a meaning structure, the relationship between the different types of routines helps to illuminate how the researched clinics and departments stabilize themselves. Third, the interdependence of different sub-systems becomes apparent with organization-wide issues that span the boundaries of the meaning structures. Together with the differentiation of self-reproducing clinics and departments, this interdependence forms the paradox of differentiation and integration.

The first results section depicts the two medical clinics of surgery and inner medicine and the nursing department. They are important for the hospital integration. In addition, they mark extreme points of plurality within a hospital as a world of caring (nursing) and curing (Glouberman & Mintzberg, 2001a). Within the latter, surgery exemplifies a core invasive profession and inner medicine a central non-invasive one (Kellogg, 2011; Vogd, 2006). Each description starts with the understanding of treating patients, of the organization, and of the reflective routines, followed by the integration account.

The second results section shows that organizational members are aware of the plurality, which they call “garden thinking”. At the same time, they note the rising need to integrate the different clinics and departments when handling organization-wide issues.

The analysis section begins with the comparison between the three meaning structures of surgery, inner medicine, and nursing. First, their ways of acting exemplify the differentiation between the three meaning structures. Second, the comparison suggests three similarities between them that help to explain how the meaning structures accomplish themselves. Third, the organizational actors use “garden thinking” to express the paradox of differentiation and integration. Fourth, I summarize the analysis and suggest a model of the self-referential reproduction of meaning structures and the resulting paradox. The model shows the sustained improbability of a pluralistic organization. Given the essential importance of plurality, I conclude that the paradox of differentiation and integration is foundational to the studied hospital.

At the end of the chapter, the discussion of these insights argues three contributions to the paradox literature and speaks to routine dynamics before concluding the chapter.

4.1 Results on differentiation: Surgery, inner medicine, nursing

Health professionals are dedicated to treating patients. “That is what all of us share. We want to help people so that they really get better. This is why we became nurses, medical doctors or therapists”, says Teodor, a leading surgeon. How one accomplishes this task differs profoundly. The ways of acting—i.e., the patterns of who becomes involved on what, how, and when—discern between the selected clinics and the department. The ways of acting express the different organizational understandings of surgery, inner medicine, and nursing in terms of their patient treatment, their organization, their reflective routines, and how they pursue organizational issues.

4.1.1 Surgery: Patient treatment, organization, reflection, and integration

4.1.1.1 Performing surgeries

Teodor, a leading surgeon, summarizes the core of *patient treatment in surgery*: “The success of a surgical intervention is based on three things: the right diagnosis, the right operation and the right after-treatment.” In this three-step sequence, the operation is

central: “We surgeons want to operate on people – as many as possible” adds Anton, another leading surgeon. Conducting surgeries is the central routine within surgery.

The *scope of focus* within the operating theatre is the uncovered body part ready for the incision. Likewise, I observed in the wards this focus on the organ, when surgeons asked nurses, for example, “where is the colon?” instead of using a patient’s name. Performing surgeries is complicated manual work that the surgeons describe as a craft: “Surgery is a craft. What you have always done by hand and well, you do not change as quickly as a medication, like the internists do” (Teodor, leading surgeon). As a craft, surgery depends on the capability of the individual surgeon. Anton, a leading surgeon emphasizes: “It is the ultimate quality assurance when the head is present [at an operation].” Furthermore, good surgical practice depends on speed and decisive actions: “Speed is important,” explains Teodor. “In many situations you don’t have time to reflect – either I go to the operating theatre, or it’s all over.” Therefore, each clinician has a pager device so that others can reach him quickly. Throughout interviews and meetings, the pager buzzes regularly. Often, the surgeon departs and heads for the operating theatre.

4.1.1.2 Organization to extend the head surgeon’s skill

The *organization* of the surgery clinic corresponds with the idea of conducting surgeries. The surgeons’ individual knowledge, experience, and manual skill are of central importance. Such an individual style of the surgeons poses the challenge of internal fragmentation. John, the head surgeon, states: “It cannot be that everyone operates as he thinks suitable”. In order to ensure the same surgical practice, the organization is aligned with the head surgeon’s personal skill. Asked for his clinic’s success, John replies: “the fish starts stinking from the head.” The alignment to the head surgeon’s skill is widely accepted. Andrew, an assistant surgeon, notes: “you need a clear protocol and you must pursue it even against resistance. You cannot just say every time that we deviate here and there a bit. That is clear; you must have a directive for the whole unit.”

The alignment to the head surgeon’s skill is achieved first by specific guidelines. They “enable me to act”, says Kathleen, a recently appointed senior surgeon who memorized the guidelines before our research interview. John, the head surgeon, explains “we explicitly define and rule as much as possible … Everything is tightly organized – there are norms, guidelines and standards for everything in my clinic - 1200 pages. With clear guidelines everything is easy to handle.” Second, the surgical clinic displays a top-down

hierarchy alongside the surgical expertise of those holding a certain position. “The clinic is heavy on the head”, explains John, “we have a strong and clear hierarchical structure.” Teodor, the leading surgeon, pinpoints the clinical hierarchy in terms of the operating theatre: “It comes down to the fact, that there is one person with a knife who makes the cut”. Third, leading a clinic requires control from the top. Decisions are declared by John, who also delegates issues to his subordinates by giving respective orders. “Of course, everything goes over my desk. That is a fact. But I can also delegate topics very well to my leading surgeons.” He continues his view on conducting organizational change: “When I detect a problem, I record it and think of a solution or a change. Yet, I do not implement it. I tell my leading surgeons what I want, and they implement it then.”

4.1.1.3 Organizing routines of developing guidelines and reporting

Organizational routines, which pursue tasks outside the central focus of surgeries, appear to not be the main focus of the surgeons. They label these tasks as “administrative work” in a down-grading manner. Likewise, they call formal requirements for reporting on projects “projectities”, indicating an illness. In our observations, we note that surgeons regularly perform the documentation of treatment in between their surgical work before or after their shifts. The same appears to be the case of man-power planning, which applies to assistant doctors and is geared to their training requirements and restricted by their limited work hours. We did not observe the performing of this routine. In comparison, the continuous adaptation of surgical guidelines is more in focus, both situatively and regularly. Situatively, adapting surgical guidelines follows a treatment situation as the following anecdote by John illustrates: “For example, last week I was called to a surgery at Reho during the evening. They had a surgical problem. To me, it was crystal clear that the head down there, my representative, had done a surgery that is just not allowed to be done there […] I finished the surgery, got the patient up here into the intensive care unit, so that was handled. Then, I went to my office, and I wrote a new guideline clarifying explicitly what is allowed to be done there and what is not." All clinicians receive such adaptations of the guidelines electronically on a handheld device. Also, adaptations of guidelines result from the reflective routines.

4.1.1.4 Reflective routines to stay on top of surgical practice

The *reflective routines* at Laho’s surgery clinic resonate with conducting surgeries and the organizational understanding. The reflective routines mainly focus on training newcomers, staying attuned to advancement in science, and detecting errors in clinical

practice. First, training newcomers occurs on the job: They spend the first year on the head surgeon's ward of privately insured patients. John, the head surgeon, explains: "All my medical doctors spend a year on my ward and do every surgery with me. There they learn best how we do surgeries. They learn my style." Furthermore, surgeons in the upper hierarchy train lower ranks during surgeries. Finally, the daily radiology rapport is said to fulfill training goals in analyzing x-rays and in concluding surgical measures.[12]

Second, the clinic conducts a monthly meeting to discuss selected surgeries and to focus on the challenges, specific surgical practices, and material to successfully complete a complicated incision. For John, the head surgeon, it is important that "improvements are made systematically. We record all complications electronically. Once a month, we have our complications conference and discuss all entries. We see where errors occur and immediately derive the necessary consequences."

Third, the clinic for surgery aligns with the state of the art by means of the "Journal club". Four times a week, the surgeons discuss scientific articles selected by the head surgeon who appoints subordinates to present them. "And then we can detect, whether we are in line with the international development or need to improve something" (John, head surgeon). Frequent attendance of medical conferences by the head and the leading surgeons accompany the detecting of new developments.

In summary, the core routine of conducting surgeries means to act on the scope of the organ with rapid, individual decision-making within hierarchical structures and explicit guidelines. Thus, the ways of acting orient to the top of the hierarchy, and the organization is the extension of the head surgeon's knowledge and manual skill.

4.1.1.5 Integrating the surgical clinics: conducting a "surgery"

The way of integrating Reho's surgery into that of Laho resonates with this meaning structure. The initiative lasted for about six months and occurred prior to the officially declared start of the hospital region. Figure 4-1 summarizes the process of integrating Reho's surgery into that of Laho, followed by a description of the unfolding events:

[12] As an observer of the radiology rapport, I was not sure as to the degree to which these meetings were able to fulfill training purposes. The rapport usually lasted for 15 to 20 Minutes during which 20 to 30 cases are demonstrated. Quite often, the picture was displayed, and the head surgeon or one of the leading surgeons stated the resulting surgical intervention.

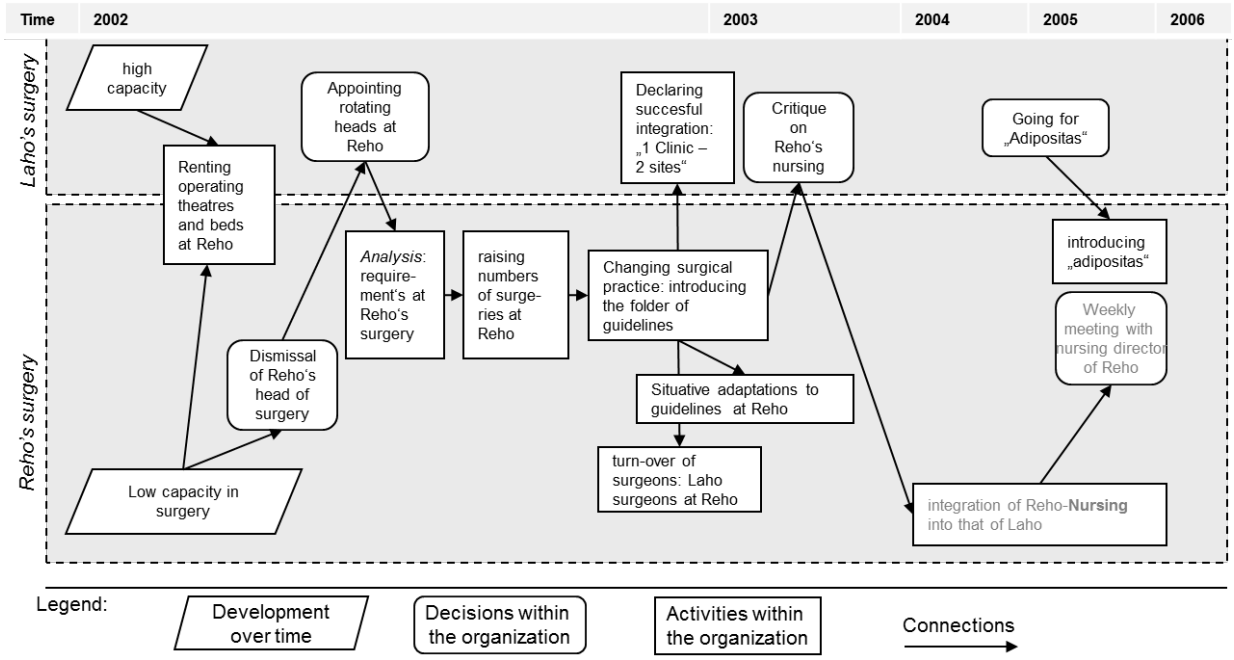


Figure 4-1: Integration of the clinics for surgery

The integration of Reho's surgery clinic into Laho's is triggered by the capacity problem and the departure of Reho's head of surgery. Anton, Laho's leading surgeon, who ran Reho's surgery during my field phase, describes three steps that mirror the way of acting in surgery: "After we got started at Reho, it had three phases. The first three months were with Dr. X who addressed what was required in terms of equipment and so forth. Then, Dr. Y basically aimed to raise the number of surgeries at Reho, so that we had a solid base. The major changes in surgical practice then became my job. The surgeons are my subordinates down there." Conversely, these surgeons acknowledge that "besides Anton, the boss at Laho holds the ultimate responsibility."

The integration process of Reho into Laho mirrors the routine of doing surgeries: diagnosis, incision, and after-treatment. Anton, Reho's head surgeon, diagnosed it as lagging: "We [at Laho] are tightly organized. But that wasn't the case in Reho. It is just a primary care hospital and everything is a bit slower." John, Anton's superior, defined the goal accordingly: "We want to have the surgical department down there exactly identical to ours [Laho]." The intervention was to align Reho's clinical standards with Laho's concepts. "We revolutionized everything… We did not develop anything anew. We just needed to bring all our 1200 guidelines to Reho" (John). For Anton, implementing the guidelines was a simple task: "We took our guideline folder down there, and then we simply had to condition the people to follow them. We coerced them into our way step

by step. ... But that was easier than I thought, because most of the personnel quit and looked for new employers anyway."

Laho's surgery integrated that of Reho in less than a year. In fall 2002, John declared the integration complete, coining the slogan "One clinic – two sites," which expressed his main goal. Three years later, the surgeons enter the new treatment field of Adipositas at Reho for treating overweight patients. Although a topic of inner medicine, surgery takes the initiative, offers the service, and later recruits an internist to handle the issues outside their range of expertise. While internal medicine laments this process, Nada, the nursing director, expects: "We will earn revenues and nobody will say anything."

4.1.1.6 Summary and validation of the surgery meaning structure

The narrative demonstrates that integrating the clinics resonates with the treatment routine of conducting surgeries and the organizational understanding of surgery. The head surgeon of Laho delegated the integration to his representative at Reho with tight control and immediate response as problems arose. The scope of the integration was tightly defined by the surgical guidelines to be implemented at Reho to adapt its surgical practice to that of Laho. The process of introducing the adaption was coercive, which allowed the integration to be completed in six months, albeit with replacing Reho's surgical personnel.

Internists and nurses confirm the surgeons' meaning structure. They view that their colleagues focus "only on the immediate problem". An internist noted that surgeons still remind him of past heroes: "They still remind me of those heroes of the past who operated the whole night and continued the next day. That was really dangerous back then, but looking at them today, they still show this attitude." In the context within the hospital, the clinic for surgery appears to others "very demanding, and aggressive. They just state what they want and do what they like. Period!", says Marvin a senior physician of Reho's inner medicine. Nada, Laho's nursing director, comments to me on an internal conference watching the head surgeon entering the room with his senior staff behind him: "Look! Here comes: Le roi et moi. In surgery, they do not need an organization." Furthermore, the literature confirms surgery as a heroic, individualized affair that is tightly focused on the immediate issue at hand (e.g. Kellogg, 2011).

4.1.2 Inner Medicine: Diagnosing and meeting structured organization

4.1.2.1 Diagnosing

Internists at Laho focus on closing "*diagnostic gaps*", says Tim a senior physician: "When a patient arrives, the daily and core challenge is to clarify what is going on. Let me say: to close the diagnostic gap. Really figuring out and imagining what the problem could be and what is required sooner rather than later." Internists regard the patient as a "complex system" (Margit, assistant doctor). Relating a range of symptoms to a diagnosis as their explanatory principle is the core challenge because: "The limit of evidence-based medicine is the complex individual patient" (Paul, head internist).

Internists examine the physiological and psychological dimensions and include the medical history besides the present situation. These areas are complemented by the family history and the social factors. Diagnosing is guided by so-called algorithms. Algorithms are analytic steps to capture relevant information over time and to guide the systematic generation of diagnostic hypotheses. Diagnostic hypotheses are preliminary, and the data are open for different interpretations. The algorithm provides a systematic sequence to assess the patient situation at hand.

Diagnosing and defining corresponding treatments usually involves a collective performance. We regularly observed internists and nurses standing in conversation. The goal is to "reach a consensus" or a collective achievement, explain Tim and Mathew. Doing so requires individual expertise, "evidence and intuition", states Paul, the head internist. It is important that "everyone knows his field of expertise so that we can exchange our views", adds Tim, the senior physician. The nurses' perspective is an important ingredient in this process, as we observed continuously on morning ward rounds, or during the afternoon handovers from one shift to another, where medical doctors discuss patients. Paul notes that he is "glad when they [the nurses] have a complementary view on a patient." Discerning the underlying root of the different symptoms is a time-consuming task. It requires monitoring the patient and her symptoms thoroughly over a period of time: "You watch the patient," states Margit, an assistant internist. Diagnosis is accompanied by a variety of observations and analyses that generate and are guided by diagnostic hypotheses. The internists "need to wait to arrive at a consensus", notes Mathew, senior physician at Laho's inner medicine.

4.1.2.2 Organization for diagnosing around meetings

The clinic of inner medicine orients around the senior physician or leading internist who is responsible for a ward: “In inner medicine you actually do not really a need a clinic head anymore. The senior physician is to be capable of handling all patient issues with the support of the other internists”, explains Paul, the clinic head. At the same time, meeting routines are a prominent way that structures the clinic of inner medicine. As in surgery, the morning starts with the “radiology rapport”. All medical doctors meet and are informed of incoming and outgoing patients, results of examinations by the radiology department, and on noteworthy events on the different wards. After the morning ward round of senior physicians, assistant doctors, and nurses, the assistant doctors and their superiors meet for training called the “round of small cases”. Throughout the day, internists attend rapports of other clinics like cardiology, rheumatism, or the stroke unit to review the respective patients with their colleagues. “We are the oil of a large gear box, and present in many clinics”, explains Tim during a feedback workshop.

There are also meetings oriented towards organizational topics. At the daily “physicians’ rapport” and at the weekly “leading physicians meeting”, the senior physicians meet to converse over a wide range of issues, including patient treatment, personnel, news from the hospital, etc. In comparison to the meetings on patients, these meetings appear rather informal with the attendees raising their own issues. The clinic head uses a notepad with a list of his issues of concern. Besides, the meetings do not appear to be explicitly prepared. We did not notice an agenda or meeting minutes.

4.1.2.3 Organizing routines of reporting and manpower planning

Routines concerning organizational tasks are performed at the margins like in surgery. Accompanying medical doctors, we observed that they attend to the “administrative” tasks often before the radiology rapport or in the evenings after the last ward visit. Besides emails, these usually include documenting their treatment work and dictating reports for the secretaries. The monthly man-power planning concerns assistant doctors. Like in surgery, it mainly addresses their training requirements. As we observed, manpower planning is performed by the clinic manager who discusses open issues with the responsible senior physician in between ward rounds.

4.1.2.4 Reflective routines in inner medicine to keep up with the field's development

As in surgery, the *reflective routines* in inner medicine focus on attending to their field's development, training newcomers, and improving clinical practice. Internists attend international conferences and conduct a Journal club once a week. The group of senior physicians suggests and jointly selects the articles. Training junior staff takes place on the job as well during the ward rounds. Furthermore, the radiology rapport is said to fulfill this purpose so that the assistant doctors are to sit in the front rows. Central to training is the so-called daily "round of small cases" attended by the senior medical staff and the assistant doctors. One of them presents his patient case according to the algorithm to generate diagnostic hypotheses and suggestions for further examination or treatment. The group reflects on these contents and on the use of the algorithm. In a similar fashion, the weekly meeting of "the week's case" welcomes a larger group that includes other inner medicine disciplines. The attendants discuss complex and medically interesting cases. The group of around 40 professionals reflects on the treatment process and on the diagnostic hypotheses before drawing conclusions for further improvements.

Summarizing the meaning structure, diagnosing is at the center of the patient treatment in internal medicine. Collectively accomplished, the internists focus on the interacting physiological and psychological factors and on emerging patterns over time. Diagnosing is a central treatment routine that acknowledges the complexity and ambiguity of the individual patient. Patient treatment takes time. Diagnosing often requires consensus after including a wide range of data on the patient and of scientific studies. In line with this patient treatment, the clinic's organization places importance on the senior physician or leading internist responsible for a ward. The clinic's main structure is meeting routines to relate different views and topics raised by the attendees with the aim of achieving consensus. While meetings on patients display an explicit structure, internists handle organizational issues rather informally, but similarly they aim for consensus based on a broad exploration of the situation.

4.1.2.5 Integrating the inner medicine clinics: observing and acting as it unfolds

Inner medicine undertakes the integration of Reho's clinic into that of Laho differently from surgery, in line with their meaning structure over a period of about two years, and significantly after the official beginning of the hospital region. Figure 4-2 displays the integration process of inner medicine that is described below:

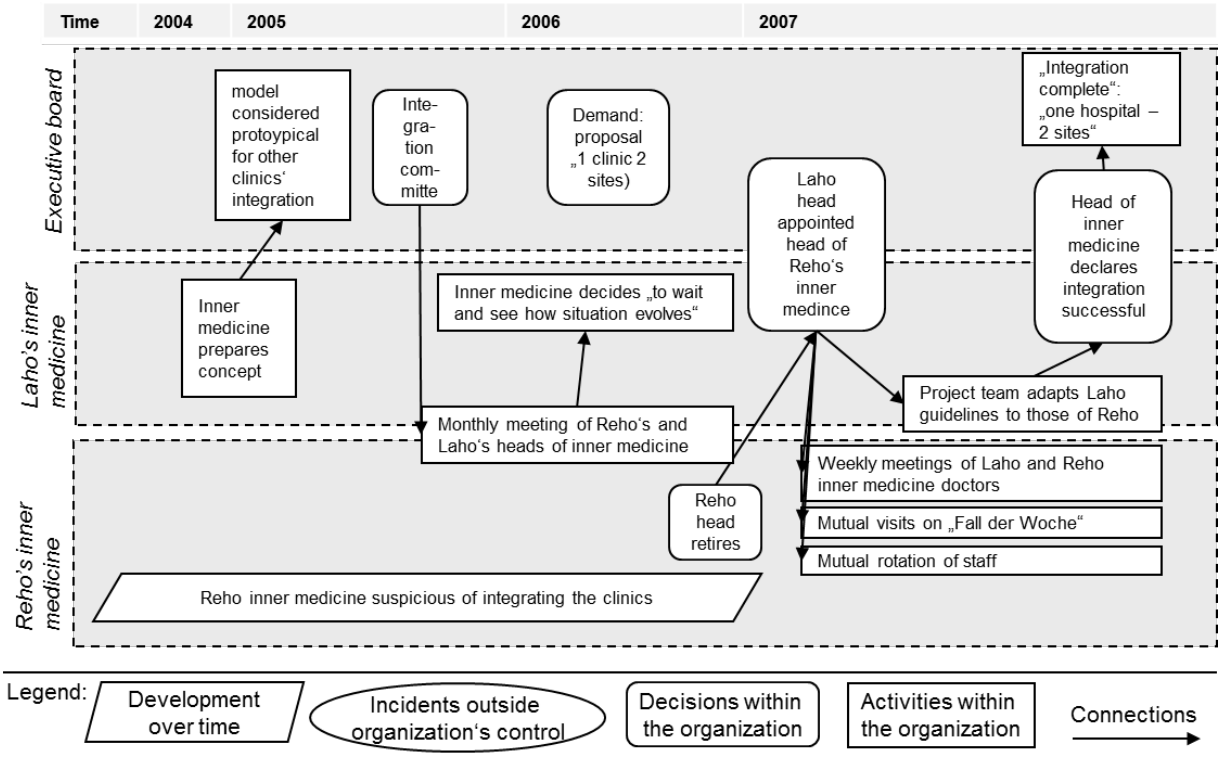


Figure 4-2: Integration of the clinics of inner medicine

Internal medicine begins the integration of Laho's and Reho's clinics during fall 2004 with Laho's head internist preparing a conceptual model of an integrated department, which he presented to the executive board in January 2005. The board acknowledges the model and suggests it to be the prototype for all clinics and departments. In summer, 2005 the executive board initiates the so-called integration committee. Within this monthly meeting, Reho's and Laho's heads of internal medicine discuss the integration. Perkins, Reho's head internist, does not welcome the integration in June: "I do not think it realistic that our clinic at Reho can be run by someone from Laho. They are just too far away from what is going on here." Paul, Laho's head internist, senses this doubt. During a regular meeting with his leading internists of Laho, he reports his insecurity of Reho's expectations. At the end of their discussion, Paul concludes: "Let us wait and see how the situation develops. Then we will know how to position ourselves and how to proceed." In March 2006, the executive board of the hospital requests another proposal from inner medicine on the clinic integration, following the surgeons' theme of "one clinic – two sites." Paul explains in a research interview that he does not know what it could look like and that he does not know how to integrate the clinics even if he did. Paul feels reluctant to the integration: "There is also a political and local context I do not grasp. After all, Reho is a hundred years old. We cannot just go there and change

things." Laho's department of internal medicine becomes active at Reho after Reho's head internist retires in December, 2006. During 2007, Reho's internists participate in Laho's "the week's case" meeting and in their "journal club". Mathew, a leading internist of Laho, explains: "We need to develop a shared practice before we can adapt Reho to our algorithms." The internists of both hospitals agree on mutual job rotation for assistant doctors and their direct superiors who run the wards. By the end of 2007, Laho's head of internal medicine is appointed to lead the clinic of Reho. In the following annual report, the executive board declares the integration of internal medicine as well as that of the hospital a success.

4.1.2.6 Summary and validation of the meaning structure of inner medicine

The story of integrating internal medicine resonates with the diagnosing routine central to inner medicine. On the one hand, it was Laho's clinic head and his group of senior physicians who regularly discussed the integration and later implemented joint workshops, the journal club, and job rotation. At the same time, it appeared important for them to seek consensus with their Reho colleagues. Seeking consensus and waiting to observe the emerging situation before acting on the opportunity of Reho's head internist retiring summarizes the way internal medicine conducted the integration. Doing so made sense for the internists as they acknowledged their ignorance of a situation they perceived as complex. The perceived complexity indicates the scope of what internists took into account: the local and political situation of Reho and the sensed expectations of their Reho colleagues. Laho's internists provided for developing a shared way of acting before adapting Reho's algorithms. Thus, the clinic integration resonates with the meaning structure of inner medicine at Laho.

The surgeons validate this meaning structure. They describe internists as "academics" and themselves as "craftsmen". A surgeon comments: "[The internists] mutually borrow and lend their brains and think together." They "require a lot of time" to reach a conclusion. A nurse adds that "internists look at everything, the whole situation of the patient". Organizational literature resonates with these findings in that diagnosing is central to patient treatment and that inner medicine places emphasis on collectively exploring changes within their clinic (Edmondson et al., 2001; Vogd, 2004).

4.1.3 Nursing: Caring for sick people and organization between the clinics

4.1.3.1 Caring for sick people

The core routine in nursing is to care for a sick person, Jill a Reho nurse describes: “When I meet a person for the first time at the hospital I am about to say: You are at our hospital now – and I am responsible for making you feel well.” In caring, nurses distinguish between illness and person: “It’s not about the cancer, the illness. We care about the person” (Nada). To this end, it is essential to establish a personal relationship with the patient. “In nursing, it is about listening and letting people talk” (Jill).

The so-called “care anamnesis” provides a systematic guide to assess the physiological, psychological, and social situation of a sick person, including their fears and expectations. Based on these insights and the medical instructions, the nurse plans the care activities, for example, food provision, hygiene support, treating wounds and ensuring appropriate medication. The nurse in charge of a patient also coordinates the patient’s exit, like arranging the after treatment, home care, or informing the family doctor. These activities are performed in teams because each nurse also holds special expertise on certain nursing activities besides being designated to particular patients. As common, the nursing department at Laho practices a so-called “primary care concept”.

In terms of time, a nurse accompanies a patient from his arrival until his exit and interacts with a particular patient several times a day keeping in mind the patient file to depict the trajectory of the development. Jill summarizes “It is about spending time with the patients”. Paul, the head internist, adds: “The nurses are much longer along-side the bed whereas I only come in on my ward rounds and only see the person at this moment.”

4.1.3.2 Organization for caring between the clinics

At Laho, the nursing department is separate from and positions itself in between the clinics. Nada, the nursing director, explains: “With the ever increasing specialization in medicine, our role of delivering service will be strengthened. […] We always care for many different medical disciplines simultaneously and connect them.” Therefore, she conceives her department as the “protective coat”: “We are the ones holding the disparate activities together. This is the matrix role we have and that gives us strength.”

Resonating with this position, the nursing department bears similarities with surgery and with inner medicine. *Like surgery*, Laho's nursing department holds a hierarchical structure with the nursing director, the clinic head nurses, and the ward head nurses. The nursing director decides on organizational issues like personnel, budgeting, planning staff capacity, new nurse concepts, or collaboration with clinics. Furthermore and similar to the surgical guidelines, the nursing unit uses an "exemplary file" that contains the standard operating procedures of caring and other routines like the definitions for monitoring and documenting patient data. The exemplary file provides guidance to nurses, and we observed them regularly consulting it for specific care procedures. *Similar to inner medicine*, the focal point of nursing is the ward. The head nurses hold a central position in managing the team. Hana, a head nurse at Laho, states: "In primary care, the head nurse has to be the head of her team…." Rachel, Reho's nursing director, adds: "you care for a good and productive climate on your ward". Second, nurses seek consensus within meetings. For example, we observed monthly team meetings run by the head nurse with an official agenda and documentation. In these meetings, the team discusses the respective topics in length until they reach an agreement. In contrast to the medical professions, the nursing unit places explicit emphasis on managing its teams and the department. Nurses in upper hierarchy are not involved in caring activities, whereas clinic heads still treat patients. In terms of further training, topics like team leadership, management by objectives, or project management are common.

4.1.3.3 Organizing routines as prerequisites for caring work

O*rganizing routines* are considered as an important pre-requisite to run a nursing unit. Documenting care activities timely and consistently "helps to demonstrate all the work we do", explains Dolores, a Laho nurse of surgery. These data feed into a monthly report for the nursing director about the overall care activities that are the bases for billing the clinics internally. Also, the data provides a consistent overview of the patient population as well as entries and exits. Finally, the monthly report provides insights to the degree of workload, which is an important piece of information in the hospital's annual budgeting. Such data and the manpower planning are important to run a nursing unit: "These are all things I need to work with", says Rachel, the nursing director of Reho. Manpower planning, called a "duty roster", indicates that the human resource allocation is oriented towards the nursing unit's requirements. In comparison, we observed manpower planning in inner medicine or in surgery to align with the further training of assistant

doctors but hardly with the unit's work load. Vivian, a nursing developer whose team assists wards in continuously improving their work, summarizes the protective and guiding role of the nursing standards: "In my view, all these nursing standards protect the patients, and us, and they guide us when we do our work every day."

4.1.3.4 Reflecting routines to further develop caring routines

Reflecting routines within the nursing department at Laho are a means to continuously adapt to the ongoing developments in the medicines and the nursing science. Most commonly, these topics are worked through in three ways: First, the ward teams discuss difficult cases internally and weekly for about an hour. A nursing developer participates in this meeting in longer intervals. The nursing developer is a member of the so-called "nurse development" team within the nursing department, which keeps track of the advancements in the field. The team's discussion of difficult cases broadly involves a presentation of the case and is enriched with context information about the social and psychological situation by looking at the patient's file. In the discussion, the participants explore reasons for the arisen situation as well as conclusions for how to handle the case in particular and how to approach similar future situations. The second means of continuously developing nursing standards prolong over a longer period of time and concern nursing standards more generally, for example, treating wounds and ensuring hygiene on the wards, food provision, and support. The nursing developer forms project teams with nurses of different wards that assess the existing standards in light of present state of the art in nursing and medicine. The project teams adapt the standards by changing forms or written instructions. They distribute the adapted standards to the wards. Often the nurse of the project team communicates the changes in her ward's monthly team meeting. Sometimes a revision is accompanied with a specific training session for all ward nurses. The third means is that a nurse developer accompanies ward nurses in their daily work: "I accompany nurses in their work with the patients, and then we document afterwards on how they actually do the standards so that I can give direct, concrete feedback what went well and where to improve. … I cannot just hold a meeting and say: This is how we do it from now on, here are the forms and checklists, go for it."

To summarize, caring for sick people is at the core of nursing. Caring incorporates physiological, psychological, and social factors to grasp the patient's situation. Caring means to establish relations over a period of time and involves both the individual nurse and the team to accomplish this effort. Professional care at this hospital is based on a

distinct “nursing anamnesis” that is oriented along the collection of explicitly developed nursing operating procedures that are documented in the “exemplary file”.

In terms of their organization, the nursing unit positions itself between the clinics as a separate department. Resonating with this position, they employ both a top-down hierarchy for organizational topics combined with an emphasis on structured meetings to systematically include the expertise and the perspectives of the involved nurses. In difference to the clinics the nursing department uses documenting and manpower planning routines to run the wards.

4.1.3.5 Integrating the nursing units: including the nurses in the development

The nursing department conducts the integration of their department in their own way. Figure 4-3 provides an overview on this process.[13]

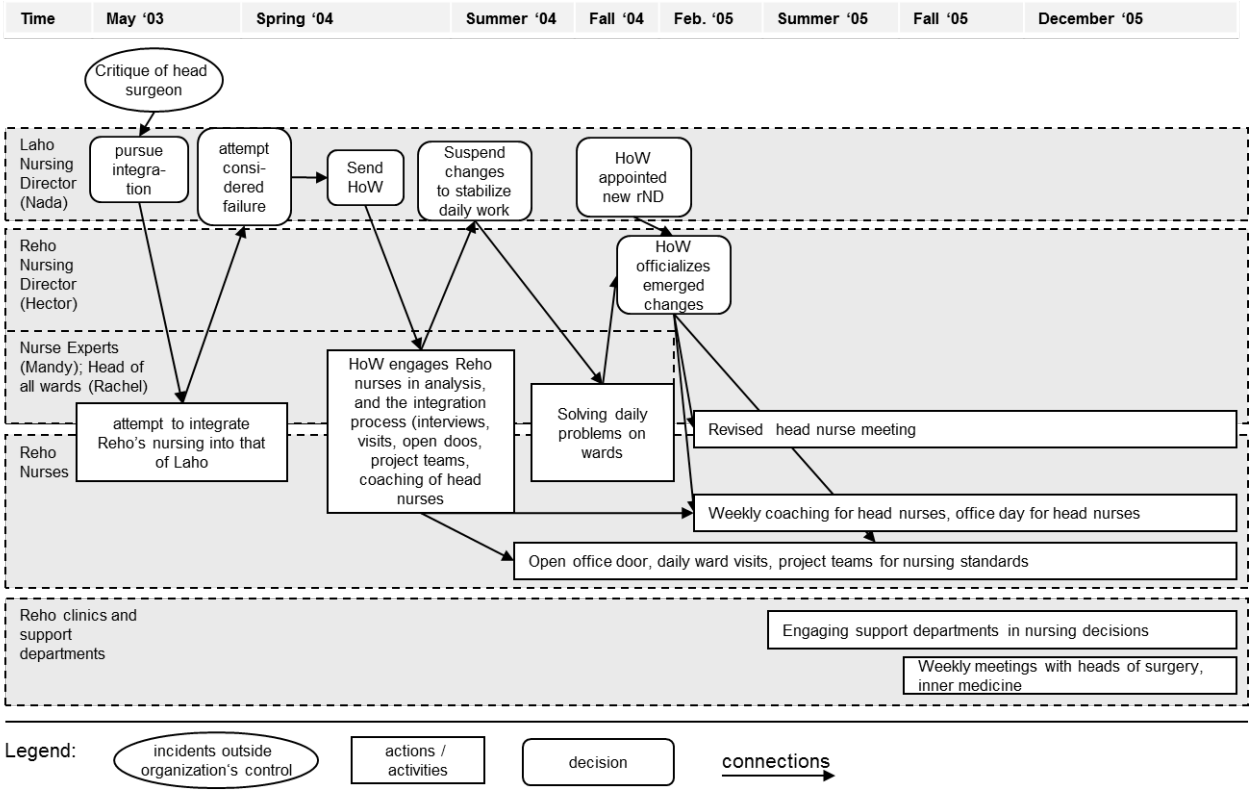


Figure 4-3: Integration of the nursing departments

Nursing begins the integration to address the complaint John, Laho’s head surgeon, remarked about Reho nurses in summer 2003. After a first and conflictual episode, Nada sends Rachel, a head nurse to Reho. From July 2004 onwards, Rachel oversees all wards at Reho and is supposed to adapt Reho’s nursing caring and organizing routines. Rachel

[13] The process of integrating the nursing departments is considered in more detail in chapter 6, but is briefly mentioned here to express the transfer of the treatment routines to an organizational topic.

first interviews all Reho nurses about the current situation, coaches head nurses on leading their wards, and supports the ward teams in their daily challenges. She leaves her office door open for nurses to approach her situatively and visits each ward twice a day to see "how they are doing." In February 2005, she becomes the nursing director at Reho and enacts a variety of changes. These changes involve the head nurse meeting with the aim "that the head nurses engage themselves in the changes we pursue" (Rachel). The daily morning meetings aim to assess the different workloads of the wards. Rachel's weekly meetings with the clinic heads are supposed to improve their collaboration. The wards engage in discussing difficult patients. Besides meetings, the work shifts are adapted and Rachel works on improving manpower planning as well as the consistent and timely documentation of care activities. In addition, Reho's head nurses participate in further training on management and ward leadership. The ward nurses adapt existing and develop new nursing standards. At the end of 2006, the integration appears complete. An external audit on nursing quality demonstrates that Reho achieved Laho's level in nursing.

4.1.3.6 Summary and validation of the meaning structure of nursing

The integration of Reho's into Laho's nursing department resonates with the meaning structure of nursing. The establishment of relationships, the participatory approach to include Reho's nurses into the change process, and the scope of activities to alter caring and organizational routines resonates with the scope of nurses on treating patients.

Medical doctors validate the nurses' view on their meaning structure. Clinicians are aware of the nurses' perspective on patients: "we are rather looking at the rational, the nurses rather at the emotional side; they are also closer with the patient." Some medical doctors lament "Nurses always have to talk about everything in a lot of detail, whereas we as doctors are more rational. If a study provides proofs and if a colleague has seen it works, then, we just go ahead." Also, medical doctors validate the professional organization of nursing, like the head of cardiology: "The nursing department emphasizes leadership and management much more than we do." Marvin, a senior physician of Reho, confirms: "The nurses are so well structured with their documenting and man-power planning and all. We, the medical doctors, are too dumb for that." Demonstrating their professionalism is also common in other hospitals (Apker, 2003;

Reay et al., 2006). In comparison, in many hospitals the nurses are subordinate and part of a specific clinic (Kellogg, 2011; Stratmeyer, 2002) but a separate department at Laho.

4.2 Results on integration: "Garden thinking" and organization-wide issues

The previous section depicted the plurality of the hospital by describing the three meaning structures. Each of them enacts their own organizational understanding that associates with respective treatment, organizing and reflective routines.

The practitioners are aware of their hospital's plurality. Within the description of each meaning structure, I noted the practitioners' views on their colleagues. These mutual observations suggest that the differences between surgery, inner medicine, and nursing are salient in the daily work of the organizational members.

Further elaborating on the observed plurality, the following section contains field data on "garden thinking". "Garden thinking" is the label of the organizational members for the plurality they observe. Simultaneously, the organizational members note the need to jointly work on organization-wide issues to further advance their hospital.

4.2.1 The practitioners' awareness of "garden thinking"

The salience of the differences is ubiquitous throughout the hospital. Table 4-1 provides interview data of Laho's executive board members on "garden thinking" that illustrate the awareness of the plurality as differentiation:

Interview Partner	Data excerpts	2nd order concept	Aggregate dimension
Nada, nursing Director	"Everyone cultivates their own garden, the surgeons, the internists and the administration.... Ultimately the members in the executive board represent particular interests."	Attending own interests	Differen-tiation
John, head of Surgery	Everyone looks after their own garden, the internists, the surgeons, and the administration.		
Pablo, head emergency doctor	There are clinics that put their own interests first and not that of the whole hospital. It becomes difficult then because you cannot throw this truth to their heads directly.		
Nada, nursing director	When I think of some clinic heads, they act like lightning. 'I want it, and I want it right away'. Then they are active and do a lot.	initiative of clinic heads	
Damian, head of interdisciplinary medical services	This is how the medicines have developed, with increasing specialization and this specialization manifests in the different clinics with their respective associations and titles	Specializa-tion	
Robin, head of	You have to let the clinics have their individuality. It is essential to	Individua-	

Interview Partner	Data excerpts	2nd order concept	Aggregate dimension
Finances	ensure their professional work of treating patients so that they can obtain the most also for the entire hospital	lity of the clinics	
Robin, the head of finances	Where I was before, the board had the right to coercively define what was to be done. Such a right does not exist here, not even slightly. You cannot tell the clinics or departments what to do. That does not work"	No coercive power	
Gabriel, head of organization and infrastructure	Of course in the board we first have to think of the entire hospital. But that is not so often the case for the clinic heads. They have to develop their specialty so that they continue to be successful.	Speciali-zation	
Hank, Laho's CEO	The clinics run themselves. With their high degree of inter-relations and with their continued high autonomy, a lot of issues go through the informal networks of personal relations between the clinic heads.	Autonomy	
Hank, Laho's CEO	"The issues must originate from the units. You cannot just tell clinics top-down or from outside: 'You have to do it!' Instead, a topic must originate bottom-up. It needs to address the clinics' demands. And with some incentives for enhancing collaboration you can move it forward, and coordinate it from the top. But in essence, topics need to grow from the bottom."	Autonomy	
Gustav, president of Board of Directors	Personally, I believe that the clinics discuss the topics among themselves, and that is done in private one-on-one conversations. … And you cannot really see how that works in detail. We just have a very strong autonomy of the clinics at Laho. Damned a lot is done informally here.	Autonomy Informality	

Table 4-1: Garden thinking

Among others, Nada, the nursing director, notes: "Everyone cultivates their own garden, the surgeons, the internists and the administration." Garden thinking labels the plurality of clinics and departments. It draws on and expresses the historic development, explains Damian, the head of interdisciplinary medical services: "This is how the medicines have developed, with increasing specialization and this specialization manifests in the different clinics with their respective professional associations and titles."

Garden thinking is mutual and applies to the units that treat patients as well as to the non-medical ones. For example, John, the head surgeon says that "the administration looks after the money, and that is good." Robin, the head of finances, states: "You have to let the clinics have their individuality. It is essential to ensure their professional work of treating patients so that they can obtain the most also for the entire hospital."

"Garden thinking" helps to protect the different departments to ensure safe, high-quality patient processes shielded from outside interruptions. Torsten, the head of anesthesiology, summarizes: "There is a strong desire for harmony. Here at Laho, you try to avoid interfering with someone else's domain, and rather try to stay in harmony with one another. That is also part of the garden thinking."

Even though garden thinking primarily emphasizes autonomy, it also involves a subtle view of collaboration between these actors. Nada, the nursing director, continues her explanation: "Well, you steal your neighbor's apples (laughs). No, no, it is also like this: you would also borrow the lawn-mower, and you would water the other's plants and trim his roses. Well, garden means: you need someone to take care when you are away. And that happens as well." Although the notion of "neighbor" highlights the autonomy of different departments, cooperation appears between them, but rather it is on a one-to-one level in specific circumstances, where one asks for the support of the other. Gustav, the head of the director's board states: "We just have a very strong autonomy of the clinics at Laho. Damned a lot is done informally here."

4.2.2 Rising importance of handling organization-wide issues

At the same time, the organizational members acknowledge that garden thinking is challenging. They perceive the rising importance of enacting a stronger sense for the hospital. Table 4-2 contains interview excerpts that demonstrate the organizational members' awareness for integration. Integration manifests in organization-wide issues that span the boundaries of the different clinics and departments:

Interview Partner	1st order construct	2nd order concept	Aggregate dimension
Sarah, project manager	It is clear that tearing down the walls between the clinics and opening ab the view to the whole organization becomes essential. But it still is a learning process.	Needed collaboration	Integration
Nada, nursing Director	Well, you steal your neighbor's apples (laughs). No, no, it is also like this: you would also borrow the lawn-mower, and you would water the other's plants and trim his roses. Well, garden means: you need someone to take care when you are away. And that happens as well.	Practices collaboration	
John, head of Surgery	Many clinic heads cannot yet imagine, that we would be better of collectively, more efficient, faster, and more profitable.	Challenge of collaboration	
Damian, head of interdisciplinary medical services	At the same time, there must be a close contact relation between the clinic and the overall organization. How that works needs to be clarified with the different clinics in detail. If we do not do that, we will end up with a mere collection of specialized clinics … This is the daily challenge of leading a hospital to ensure this relation between the part and the whole.	Challenge of embedding into the whole organization	
Robin, head of Finances	The challenging goal is to develop a different relationship between the clinics and my finance department … The medicines and the administration have to work as partners	Needed collaboration	
Gabriel, head of organization and infrastructure	To cover yourself the patient benefit always works if you have nothing left as an argument. But I ask myself, who represents their genuine interests here. I doubt that we are really organized to the patients' needs. But of course there are ways to enhance that like with the interdisciplinary treatment centers we are setting up right now. But then, we encounter the next challenge internally:	Enhancing collaboration with centers	

Interview Partner	1st order construct	2nd order concept	Aggregate dimension
	do we position these centers independently, or subsume them under a certain clinic? And how do we decide on that question?		
Gustav, directors' board president	Our strategy report to the Kanton's government states that we need to enhance the interdisciplinary collaboration. But I am unsure how it really works. There is still quite a way ahead of us.	Needed collaboration	

Table 4-2: Integration on hospital-wide issues

John, the head surgeon, laments: "Many clinic heads cannot yet imagine, that we would be better off collectively, more efficient, faster, and more profitable." Sarah, a project manager for reforming emergency care summarizes: "It is clear that tearing down the walls between the clinics and opening up the view to the whole organization becomes essential. But it still is a learning process".

At Laho, issues that require collaboration beyond garden thinking rise in number and importance. Besides integrating the hospitals of Reho and Laho presented here, the executive board had to provide its public owner with a strategy in 2004. In preparing for the looming change in the financing scheme of Swiss hospitals, the finance department aimed to establish a hospital-wide system of financial controlling. During the field phase, the hospital also began planning a new infrastructure for which they needed to envision the overall future of the hospital and that of the clinics and departments. In 2006, Swiss law required the hospitals to implement regulations on work hours for assistant doctors across all clinics. During the same period, the studied hospitals prepared an overall information technology to transfer patient files from paper to an electronic form. All of these are examples of issues that span the boundaries of the clinics and departments.

4.3 Analysis: The paradox of differentiation and integration to depict plurality

The results sections exhibit three observations. First, there are differences between surgery, inner medicine, and nursing in their ways of acting that demonstrate the hospital's plurality. Second, three similarities suggest insights on how each meaning structure reproduces itself. These are the priority to treatment, its reinforcement through reflective routines, and the transfer of the ways of acting in treatment to an organizational issue like the integration. Third, the practitioners are aware of their

organization's plurality. They call it "garden thinking", which describes the paradox of differentiation and integration.

4.3.1 Enacted plurality: Differences between the meaning structures

The three professions express the plurality of this hospital in their understanding of treating patients and organizing for this treatment work. The ways of acting in treatment differ profoundly between surgery, inner medicine, and nursing as to who does what, how, and when. *Performing surgery* involves individual action based on personal expertise and manual competence in order to respond quickly to the situation at hand. *Diagnosing* of inner medicine is a collective process of observing and interpreting, patterned along systematic steps (the algorithm). Diagnosing requires time to observe the unfolding situation and the complexity of the human body. *Caring for sick people* builds on the establishment of a relationship throughout the patient's hospital stay. Nurses focus on the person in their physiological, psychological, and social context. They employ the nurse anamnesis and a continued documentation of the patient data.

The organization around the patient treatment differs as well. In *surgery*, the challenge is the individual operating styles, which is handled by aligning all surgeons to the head surgeon. Therefore, explicit guidelines, a top-down hierarchy, and explicit orders are important to enact, and they are to be controlled by the head surgeon. Observed deviations are handled swiftly by solving the situation at hand and by adapting the guidelines. These guidelines define the space of individual action. The organization of the *inner medicine* department corresponds with collective diagnosing. The clinic is structured through meetings with joint discussions on concerns at hand. Instead of specific guidelines, inner medicine coordinates its experts through the "algorithm" to guide the systematic assessment of a patient situation. While meetings on patients follow the algorithm path, meetings on organizational topics appear rather informal and rely on the participants raising their respective concerns. At the center of the organization are the medical doctors responsible for the wards, whereas the clinic head is less prominent in patient treatment than in surgery. The *nursing department* understands itself as between the clinics. Its organization handles the challenge of caring. Similar to inner medicine, the center of care activities is the ward with importance placed on the respective head nurse. Like surgery, the nursing unit enacts a top-down hierarchy with organizational

issues. Furthermore, the nursing department places importance on leadership competence, documenting their activities, and systematic manpower planning.

The differences between the three professions express the plurality of a hospital. They point out distinct meaning structures as each of them enacts a different understanding in their patient treatment and organization of this work.

4.3.2 Reproduced plurality: Similarities between the meaning structures

Despite their differences, nursing, inner medicine, and surgery bear three similarities. First, each of them prioritizes treatment work over other issues. Second, the reflective routines reinforce this priority. Reflective routines focus mainly on the advancement of the treatment work and on training the organizational members. Third, the clinics and the department transfer their ways of acting in treatment to organizational issues, such as the integration initiative.

The first similarity is that professionals give *priority to treatment over organizational issues*. Both in surgery and inner medicine, this priority resonates not only with the clinic's organizational structure, but also medical doctors treat patients throughout all hierarchical ranks, whereas the superiors in the nursing department do not engage in caring at the bed side. Furthermore, I observed medical doctors, and in part also nurses, pursuing organizational topics such as documenting or manpower planning on the periphery either in the early mornings, late at night, not at all, or as side-topics during rapports or ward visits. Marvin, a senior physician at Reho, laments: "We are badly organized without systematic man-power planning for example, like the nurses. But, I work all day with patients just to keep things going. And then I complete the reports and that administrative work and then it is 9 pm. This is when I could think about our organization, but then I go home."

Members of administrative departments confirm the priority to treatment work. Robin, the head of finance, states: "Clearly, patient treatment comes first, and we handle the issues surrounding the clinicians' work". Likewise, Gustav, the president of the board of directors with a banking background acknowledges: "You have to ensure the patient treatment first before looking at costs and revenues."

The second similarity of the three meaning structures is that *reflective routines reinforce the priority on treatment* routines in terms of their content and in terms of the way they are conducted. The topics of reflective routines are treatment issues regarding patients and training. The surgery and inner medicine both hold journal clubs to stay attuned to the development in their field. In comparison, the nursing department delegates this task to a team of so-called nurse developers who observe the ongoing development in nursing science and launch projects for adapting nursing standards. All three professions also reflect on their own clinical practice. The surgeons meet monthly, inner medicine meets daily and weekly, and the nursing wards meet weekly to discuss issues in conducting surgeries, handling complex diagnostics, or difficult caring situations, respectively.

In addition to the topics, the reflective routines are performed in line with the respective ways of acting in treatment. In surgery, reflective routines reproduce the orientation towards the head surgeon. He controls the selection of the articles submitted to the journal club, conducts the initial training of newcomers on his ward, and declares the decisions in the monthly “complication conference”. In inner medicine, reflective routines express the importance of the collective. Senior physicians are in charge of the “small case meetings” and the “the week’s case” alongside their superior. Likewise, articles to the journal club are submitted by the senior physicians. In nursing, projects by the nurse development department resonate with the top down hierarchy but with broad participation of nurses from different wards. Accompanying nurses in care activities and weekly team discussions emphasize the ward teams.

The third similarity is the *transfer of the ways of acting in treatment to the organizational issue of integrating* the clinics or the department, respectively. Although the integration was a non-routine task, it was performed in a recognizable way by transferring the treatment pattern to this organizational issue. At the same time, the transfer displays the plurality of how the two clinics and the nursing department pursued their respective integration. Table 4-3 provides a summary of the ways of acting to integrate surgery, inner medicine, and nursing:

Category	Surgery	Inner medicine	Nursing
Who	Head surgeon: individual decision-making with limited delegation to his representative at Reho	Laho group of head and leading internists with subsequent inclusion of head internists and colleagues at Reho	Change agent (nursing director): individual leadership of predominantly group decision-making with ward leading and staff nurses
What	Problem-centered in that Reho is said to lag behind in surgical procedures and therefore needs to adapt	Acknowledging the complexity of the integration as an unknown and evolving situation in an external (community, politics) and internal (expectations at Reho) context.	Personnel centered: establishing trust, addressing Reho internal problems before implementing co-development-based changes
When	Immediate problem (operating capacity) and opportunity (departure of Reho's head surgeon); integration in less than a year	Grasping the opportunity of the Reho head internist's retirement after a period of conversations and observations; integration over a two-year period	Triggered by head surgeon's critique, with a two-year period of interaction between change agent and Reho's nurses
How	Coercively introducing guidelines, followed by rapidly responding to arising problems (change in personnel, adapting guidelines)	Observing to understand the emerging situation before acting by seeking consensus and developing a shared practice before aligning algorithms and before appointing the clinic head	Developing a trust relationship, handling challenges at Reho by placing needs of Reho staff ahead of integration agenda followed by involving subordinates in co-developing their department

Table 4-3: Ways of acting to integrate the clinics and the nursing department

The *scope* of what the three professions take into account ranges from the surgeons' narrow definitions of problems, to the broader and dynamic definitions of internists, to the relational scope of nurses. The question of *who* is involved varies significantly as well. While surgery did not include affected parties lower in the hierarchy, nursing and internal medicine did. Laho's internists sought agreement with their colleagues at Reho. Nursing aimed to engage all of Reho's nurses actively in developing the department. Accordingly, *how* to conduct the integration differed. Surgery followed a coercive strategy of "carrying down our standard operating procedures" and rapidly solved arising challenges. The head surgeon handled the patient situation and developed a new guideline. Laho's internal medicine department, in comparison, sought consensus with those responsible at Reho. They observed and analyzed over time when to integrate Reho's department into their own. Nursing aimed for a shared development of Reho's nursing department while responding to Reho's specific problems. These different paths resulted in varying *durations*, ranging from less than a year in surgery to about two years in nursing and inner medicine. Also, the *point of entry* was decided independently. Surgery acted to handle their capacity problem and integrated the clinic with the departure of Reho's head surgeon. Internists observed the unfolding situation and

became active with the retirement of Reho's head internist. Nursing responded to the surgeons' critique. These differences exemplify the plurality of the hospital integration as to how it was conducted.

The integration pattern resonates with the respective ways of acting in patient treatment as to who becomes involved, what the definition of the integration entailed, how the integration was conducted, and when as well as how long it took place. The resonance between the treatment pattern and the integration initiative in each profession suggests that the former transfers to the latter. This transfer of patient treatment patterns to an organizational issue provides guidance to the involved practitioners. More generally, a surgeon explains the organization in terms of an operating table and an individual making the incision. Nurses assume that trust relations are central, and internists acknowledge uncertainty and ambiguity of a situation as integral to their work. Thus, drawing on the established understanding of treating patients for the organizational issue of the integration provides guidance to the involved practitioners.

The three similarities between the meaning structures help to explain how surgery, inner medicine, and nursing reproduce themselves as depicted in Figure 4-4. Each gives priority to patient treatment (dotted box on the left hand side). Their reflective routines reinforce this priority on two layers. On the content layer the focus of reflective routines is on advancements in their field, training newcomers, and improving their clinical practice (arrows 1, 2). Only the nursing department adds a focus on developing team leadership and management skills systematically. On the layer of enacting, the way of conducting the reflective routines corresponds to the professionals' pattern of treating patients. The transfer of treatment patterns to an organizational issue or routines (arrow 3) like that of integrating the clinics and the department provides guidance to the organizational members. The observed and declared success of the integration process further helps to stabilize the respective meaning structure. Figure 4-4 provides a summary of the three detected ways to stabilize a meaning structure.

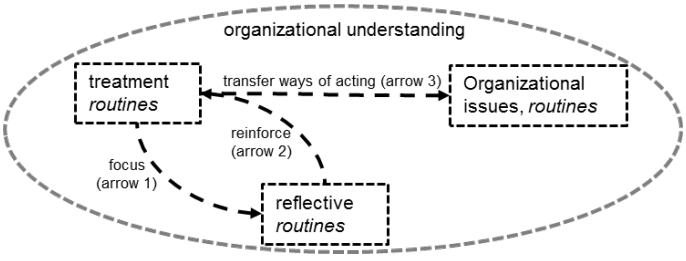


Figure 4-4: Accomplishing stability within a meaning structure

4.3.3 Observed plurality: garden thinking

In the following section, I argue that the term “garden thinking” labels the paradox of differentiation and integration. It states and legitimizes that the different clinics and medical as well as non-medical departments are each considered as autonomous domains within the hospital. These differences emanate from the historic development of the medicines and manifests in the plurality of meaning structures that is salient in the daily work at this hospital. The elaboration of the different meaning structures and their comparison in terms of their differences and similarities underscores the differentiation that is integral to Laho.

At the same time, the organizational members note the importance of organization-wide issues. There is a need for integrating the differentiated clinics and departments that manifests on a range of the afore-mentioned issues (see page 95f). Hence, the observed plurality within the organization expresses its members’ awareness of the paradoxical situation in which they find their hospital. Such initiatives are common in the healthcare sector. The literature reports process orientation (McNulty & Ferlie, 2004); quality management (Lozeau et al., 2002); lean management (Brandao de Souza, 2009; Lorino, 2014); the development of interdisciplinary centers (von Arx, 2008); or the general struggles of enhancing awareness for scarce resources in hospitals (Iedema et al., 2003; Llewellyn, 2001; Mueller et al., 2004).

In line with the literature, the observed plurality as “garden thinking” associates with the paradox of differentiation and integration located analytically on the level of the overall organization (Jarzabkowski et al., 2013; Lawrence & Lorsch, 1967; Lewis, 2000; Smith & Lewis, 2011). The paradox results from and expresses the simultaneously independent and interdependent units of an organization as a complex system (Lewis & Smith, 2014; Luescher et al., 2006).

4.3.4 The paradox of differentiation and integration

The above empirical results and analytical insights demonstrate, first, the plurality of meaning structures. The plurality of meaning structures manifests in the core routine of treating patients and in the respective organization of each clinic or department. Second,

within each meaning structure, their detected similarities reveal mechanisms of stabilizing a meaning structure. Priority is given to the knowledge-intensive work of treating patients. This focus and the way of conducting reflective routines reinforce the respective organizational understanding. Furthermore, performing a non-routine task like integrating the units of Reho and Laho suggests that it is accomplished by transferring the respective pattern of treating patients. This transfer tends to provide guidance to the involved organizational members. These three similar means help to explain the stability of a particular meaning structure. Internally, the meaning structures appear plausible and coherent. Third, the organizational members mutually observe each other and their differences. They consider the plurality integral to their hospital called “garden thinking”. Thus, the plurality of meaning structures expresses the paradox of differentiation and integration. Figure 4-5 displays these empirical insights.

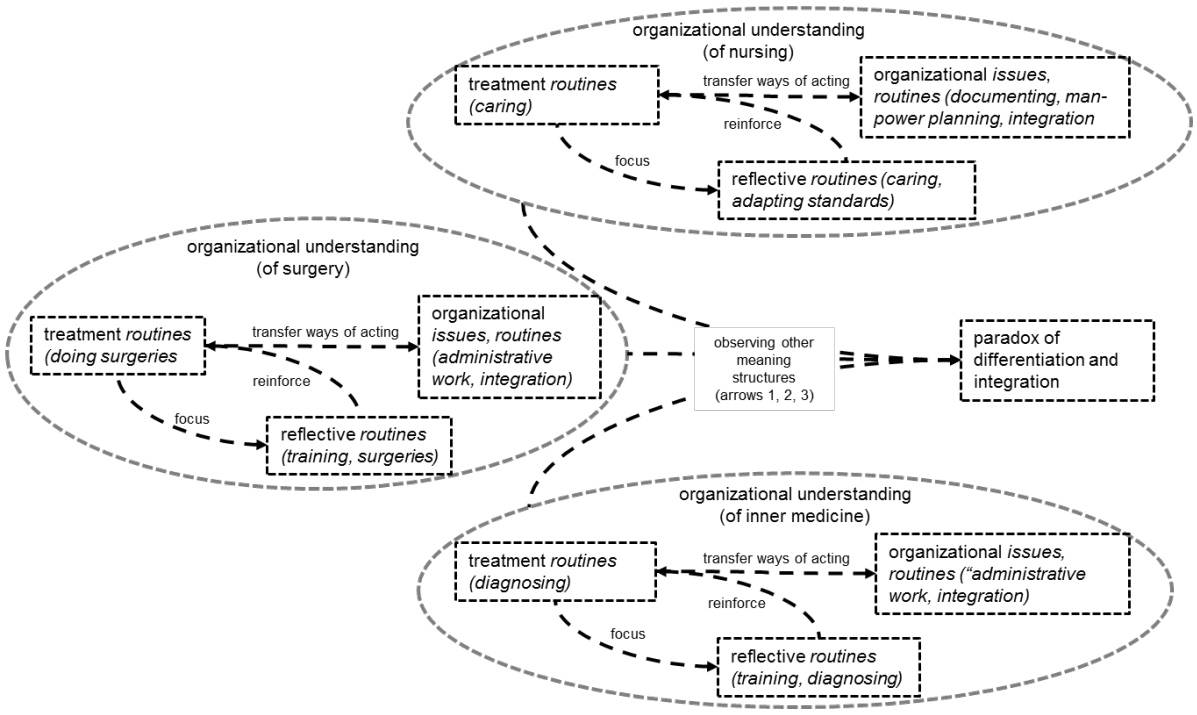


Figure 4-5: The (foundational) paradox of differentiation and integration

For the hospital, the meaning structures express a heterogeneity that characterizes a hospital as a pluralistic organization (the three ovals of nursing, surgery, and inner medicine in Figure 4-5). The heterogeneity of meaning structures adjoins in observing each other or in pursuing organization-wide issues (arrows 1, 2, 3). At such points manifests the organizational paradox of differentiation and integration. The multiple meaning structures associate with the pole of differentiation. An organization-wide initiative like integrating hospitals marks the pole of integration. The differentiation

emerges from the knowledge-intensive work the development of which involves further specialization. The specialization evokes the need to integrate the differentiated subsystems that becomes increasingly challenging. In summary, both differentiation and integration are essential and contradictory for the organization.

This summarizing theoretical model helps to explain the improbability of pluralistic organizations by elaborating on how the meaning structures differ from one another and stabilize themselves in a self-referential way. The stabilization of a particular meaning structure within this pluralistic organization involves two related aspects: first, the self-referential relationship between the organizational understanding and the routines, and second, the difficulty of reflecting on this self-referential relationship.

First, the analysis indicates that the meaning structures reproduce themselves in a self-referential way: the organizational understanding of surgery, inner medicine, or nursing associates with the respective knowledge intensive work of patient treatment. Most prominent in the clinics, the patient treatment takes priority over organizational issues. Within patient treatment, the respective ways of acting has proved to work. This pattern resonates with how the clinic or department is organized as well as with the handling of organizational issues like the integration of the clinics or the department. The way of acting in patient treatment guides the latter. In other words, the organizational members draw on the ways of acting in patient treatment to enact the organizational issue (Feldman & Orlikowski, 2011). Furthermore, the reflective routines reinforce the respective organizational understanding. They are geared towards clinical practice, training, and the development of the medical and nursing professions, which is a direction also found in other hospitals (Edmondson et al., 2001; Iedema & Carroll, 2011; Kellogg, 2011). The conduct of the reflective routines reenacts the respective ways of acting within the respective clinic or department.

Second, the self-referential reproduction of a respective meaning structure hardly becomes a topic itself. The following two vignettes of the feedback workshops (Table 4-4) with the clinicians illustrate the difficulties:

In *surgery*, we reported the dynamics and challenges of the nurses during a change initiative to introduce a new surgical regime (Bucher & Tuckermann, 2009). John, the head surgeon replied: "I never saw it this way. I thought that we had a smooth process with all of us being positive of what we achieved." Almost engaging in reflecting on the surgeons' practice of conducting change, one of his leading medical doctors reacted and challenged the methodology of our study and our understanding of management (see Iedema et al., 2004 for similar data). The head surgeon joins in disregarding our findings, while other surgeons and the attending nurses remain silent, thanking us later informally for raising the topic.
In *inner medicine*, the participants appreciated the feedback session and welcomed a language and the images we provided to describe their ways of acting. They concluded to raise their own awareness for organizational topics like internal collaboration, with nurses and with other disciplines. Instead of using their meetings to explicitly and regularly raise such a topic, the inner medicine concluded to delegate the topic to their clinic manager so that they could continue focusing on treatment issues. Like installing a nurse developer within their clinic, or a so- called "clinalyst" (Iedema & Carroll, 2011; Reay et al., 2006) for organizational issues they missed out that organizational topics lay in their responsibility. The risk is that organizational issues remain with such a position and thereby at the margin of the internists' attention, as we observed in their man-power planning.

Table 4-4: Vignettes on reflection in the clinic for surgery and for inner medicine

The challenge is that in reflecting on one's own practice, it is difficult to step out of that very practice (Zundel, 2012). Already, the way in which the reflection unfolds tends to enact the very pattern which is the topic of the reflection. The organizational members are subject to the self-referentiality of observing their own routines by drawing on the same patterns and understandings. Therefore, the self-referentiality tends to reproduce the blind spot (von Foerster, 1994), which contains the topic of the reflection. It fosters to fall back into old habits (Barrett et al., 1995; Bartunek & Moch, 1994; Westenholz, 1993). But falling back into old habits also means that self-referentiality achieves stability. The self-referential relationship of patient treatment, organizational issues, and reflective routines creates and re-creates so-called "… inviolate levels of values that conceal the contingency of basic assertions" (Fuchs, 1988: 25). The way of acting of who becomes involved on what issues, how, and when remains unquestioned within a meaning structure. It counts as inviolate because it has proven to work, trained to be practiced, and scientifically legitimated by research in the respective professional field.

The stabilization of the differing meaning structures helps to explain the improbability of pluralistic organizations. With increasing organization-wide issues, I conclude that the improbability of pluralistic organizations marks the paradox of differentiation and integration. This paradox appears foundational to the studied pluralistic organization for

three reasons. First, each meaning structure (e.g., surgery, inner medicine, or nursing) is essential to be regarded as a hospital (Glouberman & Mintzberg, 2001a). Second, the knowledge-intensive work of treating patients is central to its organizational members. Therefore, clinics and departments are structured according to the respective understanding of the ways of acting in treatment, which is reinforced by the reflective routines. Third, the knowledge-intensive work emanates to organizational issues, thus impregnating both the understanding and the conducting of topics like strategic change (Denis et al., 2001), leadership (Denis et al., 2010), or budgeting (Jarzabkowski, 2004). The knowledge-intensive work expands beyond the clinical context to the hospital at large and organizational members are aware of the paradox in this hospital. At the same time, the differentiation fuels the need for integration (Willke, 1996).

For these reasons, I conclude that the paradox of differentiation and integration is foundational for the studied hospital, which is an exemplar of a pluralistic organization. The paradox depicts the improbability of a pluralistic organization. It persists because the different meaning structures reproduce themselves in a self-referential way. The meaning structures express the different strategic goals, the relative autonomy to one another, and the knowledge intensive work of a pluralistic organization with regards to the contents and with regards to the ways of acting. Integrating the differentiated sub-systems is essential for the studied hospital. The paradox of differentiation and integration is foundational for this pluralistic organization.

4.4 Discussion: The paradox of differentiation and integration

The previous section concludes that the studied hospital is based on the paradox of differentiation and integration. The proposed model follows the general insight within the literature that paradoxes emerge from different sub-systems that are independent and inter-dependent (Ford & Backoff, 1988; Lewis & Smith, 2014; Luescher et al., 2006). The model depicts how these sub-systems sustain themselves and thereby explains the persistence of the paradox. In the following section, I discuss these insights with the paradox literature and also suggest contributions to routine dynamics.

The paradox literature notes that a paradox becomes salient in pluralistic contexts (Smith, 2014; Smith & Lewis, 2011). The paradox on the organizational level contains the poles of differentiation and integration (Jarzabkowski et al., 2013; Lawrence &

Lorsch, 1967). Studies on pluralistic settings such as hospitals have elaborated on the tensions between different groups of professionals or between clinicians and management (Barley, 1986; Bate, 2000; Denis et al., 2007b; Iedema et al., 2003; Jarzabkowski, 2003; Jay, 2013; Llewellyn, 2001).

The empirical research on and the analysis of the different meaning structures and the awareness of plurality contribute three aspects to the paradox literature. First, attending to the sub-systems in detail demonstrates that they differ not only in their perspectives and interests but also in the ways of acting to accomplish their treatment and organizational tasks. Second, the identified similarities suggest that the paradox is actively accomplished by showing how each subsystem reproduces itself from others. Third, as a consequence of the second aspect, the different actors are keenly aware of the paradox of differentiation and integration. While the literature argues that plurality entails paradox, I argue that a pluralistic organization like the studied hospital is based on the paradox of differentiation and integration. This conclusion builds on and contributes to those works that regard paradox as foundational. After elaborating on the three contributions to the paradox lens, I turn to the routine dynamics literature.

4.4.1 Accomplishing the different sub-systems

The first contribution is that plurality entails not only different interests and perspectives but also internally coherent yet different ways of enacting a meaning structure or subsystem. The scope of regarded topics, the range of actors involved, the way of pursuing a topic, the duration, and the trigger for enacting an issue vary between the studied units. In line with Lewis (2000) and Lewis & Smith (2014), my results demonstrate that each meaning structure appears coherent by themselves, but contradictory when viewed together. The meaning structures express the heterogeneity of understandings and ways of acting. The different meaning structures entail the paradox of differentiation and integration.

The paradox lens builds on the idea that a paradox emerges from independent and inter-dependent sub-systems. Their plurality is one essential condition for paradox emergence (Smith & Lewis, 2011). The plurality results from diverse external and internal demands (Jay, 2013) or diverse interests and goals (Lewis & Smith, 2014) or world views

(Glouberman & Mintzberg, 2001a, b). The paradox lens rather highlights the tensions between the poles but attends less to their local and situative enactment.

In order to understand these sub-systems, my empirical research relates the routines (Feldman, 2003; Rerup & Feldman, 2011; Stiles et al., 2015) with the organizational understanding (of a subsystem) that form a meaning structure (Hernes, 2014). Thereby, routine dynamics helps to explore how and why the studied paradox persists.

The comparison of the sub-systems shows the different patterns by which they enact their knowledge-intensive work and their organization. These ways of acting complement the paradox literature that attends to the understandings and interests when investigating paradoxical tensions. For example, Westenholz (1993) explores the contradictory organizational understandings within a cooperative as well as the members' different approaches to these tensions. This work demonstrates the challenges with paradoxical thinking, defined as "a process through which employees establish a new relationship with the situation they are in" (ibid: 56). Similarly, Swanberg O'Connor (1995) elaborates on the employees' involvement in deliberate organizational change through which a paradox of inclusion and exclusion manifests. Luescher et al. (2006) explores at "Lego" how paradoxes become salient on different levels of analysis and elaborates on their dynamic inter-relations, thus providing insights into the dynamic reproduction and therefore persistence of paradoxes. Along these lines, Jarzabkowski et al. (2013) show how paradoxes observed on the individual, group, and organizational level reinforce and mutually constitute each other throughout the restructuring process of a company. My insights complement theirs by revealing how the poles of a paradox (i.e., the different meaning structures) reproduce themselves. Like Jay (2013), my empirical data stem from a pluralistic organization, but my case extends from his top management focus to the different sub-systems of such an organization to incorporate the knowledge-intensive components. I thereby show how a paradox accomplishes itself with the independent and inter-dependent sub-systems.

Such background knowledge is relevant in pluralistic settings where paradoxes are ubiquitous (Smith & Lewis, 2011). We know that caring, curing in invasive and non-invasive treatment, and controlling label different worlds (Glouberman & Mintzberg, 2001a). We also know of the tensions between these worlds (Bate, 2000; Beech et al., 2004; Iedema et al., 2003; Llewellyn, 2001; Mueller et al., 2004). But, it remains vague

or beyond the scope of the cited studies how these worlds enact themselves. Acknowledging that paradoxes are local and situative (Clegg et al., 2002), the empirical research shows these worlds and their enactment. The different ways of acting identified in this chapter enrich the paradox literature with an endogenous explanation of paradox accomplishment in a pluralistic setting.

4.4.2 The continuous accomplishment of paradox

The second contribution furthers our understanding of how a paradox accomplishes itself persistently and thereby contributes to a dynamic view on paradox (Abdallah et al., 2011; Jarzabkowski et al., 2013; Jay, 2013). The noted differences between the meaning structures help to explain the emergence of paradox. Their similarities shed light on how the meaning structures and hence the paradox persist. The persistence of the meaning structures relates to the priority to treatment, reinforcement through reflective routines, and transfer of treatment patterns to organizational issues. These three observations help to explain how a meaning structure and the paradox of different related ones persist.

In comparison, the literature tends to deduce logically that paradoxes are integral to an organization and therefore persist (Ford & Backoff, 1988). The persistence of paradoxes is less a topic of empirical studies that mainly focus on handling paradoxes. Many empirical studies start from the assumption and a brief description of the tensions that refer to a paradox. Their insights regard how managers cope with, for instance, exploration and exploitation (Andriopoulos & Lewis, 2009; Smith & Tushman, 2005), strategic paradoxes (Smith, 2014), change and stability (Jarzabkowski et al., 2013), centralized and decentralized decision-making (Beech et al., 2004), or paradoxical tensions of belonging and of performing (Luescher & Lewis, 2008). These studies hardly explore the different sub-systems or meaning structures from which the paradoxes are assumed to emerge. As argued in section 2.2.1 (p. 32), we know little about how a meaning structure reproduces itself in light of the differentiation to other internal meaning structures.

Furthermore, empirical studies on hospitals hardly compare meaning structures. Rather, they attend to single meaning structures, like surgery (Kellogg, 2011), cardiology (Edmondson et al., 2001), nursing (Apker, 2003), inner medicine (Vogd, 2004), or management (Denis et al., 2001). While my insights confirm their findings on the single

meaning structures, my findings contribute a comparison between meaning structures within a single setting. The comparison reveals the similarities between the meaning structures that help to explain their stability as an active accomplishment.

The empirical results and analysis show that a meaning structure accomplishes stability by giving priority to treatment issues and routines, by reinforcing this priority through its reflective routines, and by transferring the way of conducting treatment work to organizational issues. These patterns help to enact and stabilize a meaning structure, which organizational members and non-members call a clinic or department. Reproducing the different meaning structures continuously enacts the paradox of differentiation and integration. While the paradox lens highlights that paradoxes exist, I contribute empirical insights on how a paradox persists as an active accomplishment that results from the enactment of the different sub-systems depicted as meaning structures.

In this respect, the meaning structures themselves and their continued enactment provide background knowledge to potential paradox solutions. Without such an understanding, the ways of handling paradoxes lack context specific insights in what they aim to alter; this fosters the open issue of how to implement them (see section 2.2.3, p. 42ff.). Organizational members make sense of a proposed solution from the perspective of their meaning structure (Barrett et al., 1995; Bartunek & Moch, 1994; O'Connor, 1995; Westenholz, 1993). Doing so tends to reproduce the meaning structure rather than triggering change of its relation to other meaning structures.

4.4.3 The founding paradox of differentiation and integration

The third contribution concerns the paradox of differentiation and integration; the actors in my study are keenly aware of this paradox. While I follow the literature in that plurality gives rise to a paradox, I argue that the studied hospital is based on the paradox of differentiation and integration.

The organizational members are aware of the paradox of differentiation and integration. The label “garden thinking” suggests that the paradox is a normal condition for the hospital. At the same time, the organizational members acknowledge the increasing importance of integration and the challenges of pursuing issues that span the boundaries of the different sub-systems. As a result and in light of the previous two contributions, I

conclude that the paradox of differentiation and integration is foundational to a pluralistic organization like the studied hospital. This paradox is a consequence of the differentiated knowledge-intensive work within a pluralistic organization (Denis et al., 2007b). Without this plurality, the organization would not be considered a hospital. At the same time, differentiation demands integration (Lawrence & Lorsch, 1967; Willke, 1996). The paradox of differentiation and integration rests on a pluralistic organization's "…combining multiple logics and therefore multiple ways of acting and making sense of organizational outcomes" (Jay, 2013: 140). My findings offer specific empirical insights on the multiple ways of acting and show the endogenous accomplishment of stability within meaning structures. These in turn support the argument that the paradox of differentiation and integration is the raison d'être of the studied pluralistic organization.

In comparison to my attendance to one paradox, the literature identifies a large range of paradoxes and places them on different analytical levels. These levels are the individual, the group, and the organizational ones that contain the paradox of differentiation and integration. While Smith & Lewis (2011) suggest relating the paradoxes and the levels in matching pairs, authors like Andriopoulos & Lewis (2009), or Jarzabkowski et al. (2013) suggest that the different analytical levels and their paradoxes are mutually reinforcing. These authors point out, that paradoxes on the individual level reinforce those on the group level and on the organizational level (and vice versa). At the same time, these authors (ibid.: 247) highlight the centrality of the organizational paradox of differentiation and integration: "the ongoing process of organizing is innately paradoxical because of the tensions between different organizational parts and tasks and the need for the organization to cohere as a collective system."

Although sorting paradoxes makes sense to handle their rising number, the literature also evokes confusion. Some works locate the same paradox on different levels. For example, paradoxes of belonging are placed on the individual level (Smith & Lewis, 2011) or on the group level (Jarzabkowski et al., 2013). These two works also differ in their positioning of performing paradoxes. Jarzabkowski et al. (2013) place performing paradoxes on the level of individuals. Smith & Lewis (2011) consider these on an organizational level. Empirically identified paradoxes appear therefore intertwined with one another (Andriopoulos & Lewis, 2009; Jay, 2013; Lewis, 2000). Sorting paradoxes to certain analytic levels appears limited to add guidance to the field.

As an alternative, I suggest relating the different paradoxes to the paradox of differentiation and integration. Assuming that organizations are complex systems (Lewis & Smith, 2014; Luescher et al., 2006) leads to viewing paradoxes as integral to organizations because tensions evolve between the differentiated components or meaning structures of the organization. In pluralistic organizations, these differentiated components manifest in clinics and departments and provide the basis to call the organization a hospital. Therefore, the paradox of differentiation and integration is not only integral but foundational to this organization. Viewed as a foundational paradox, we can interpret the range of identified paradox along the following lines. The opposition of centralization and decentralization (Beech et al., 2004) expresses integration and differentiation. Exploration and exploitation mark two differentiated sub-systems (Andriopoulos & Lewis, 2009). These two poles express different meaning structures on either exploring new and promising opportunities or generating resources by exploiting established businesses within an organization. As a third example, stability and change similarly express different meaning structures (Bartunek & Moch, 1994; Farjoun, 2010). One is proposed to alter another that is enacted. Relating them in organizational change, the two meaning structures oppose each other (Westenholz, 1993). Likewise, paradoxes of identity are often located on a so-called meso level (Smith & Lewis, 2011) and correspond with the meaning structures of different professions within a hospital, such as surgery, inner medicine, or nursing. Finally, the literature tends to place paradoxes of performance on the individual level. But, performance relates to the respective understanding of success within a certain meaning structure (Jay, 2013), so that the performance paradox expresses the paradox of differentiation and integration.

To summarize this contribution, I suggest starting by viewing a paradox as foundational in general and with differentiation and integration for a pluralistic setting in particular. Taking this paradox as a starting point provides a helpful guide for grasping the insightful complexity of organizational studies on paradoxes. Furthermore, the paradox lens itself argues that a paradox emerges from independent and inter-dependent sub-systems (Ford & Backoff, 1988; Lewis & Smith, 2014; Luescher et al., 2006). This fundamental argument implies that the differentiation of an organization opposes with and requires the need for the integration so that we can talk of “the” organization. Therefore, I conclude that a pluralistic organization such as a hospital is based on the paradox of differentiation and integration.

4.4.4 Routine dynamics extended to a pluralistic setting

While *routine dynamics* proves helpful to further advance a processual view within the paradox lens, my insights also speak to routine dynamics in at least two ways.

First, by extending routine dynamics into a pluralistic setting, the distinction of central and peripheral as well as reflective routines is helpful. It allows one to extend the common focus on a single routine (Parmigiani & Howard-Grenville, 2011) to explore the relation between routines and their different tasks (see D'Adderio et al., 2012). Furthermore, the distinction corresponds with the practitioners who grant their respective tasks different importance. Analytically, the distinction of different types of routines enables comparisons between the routines within one meaning structure like a clinic or department as well as between them to specify their differences and similarities.

Second, routine dynamics has extended towards the organizational context (Howard-Grenville, 2005) which includes the organizational understanding (Feldman, 2003) and is composed of other routines (Feldman & Pentland, 2003). Here, I find a meaning structure (Hernes, 2014) to be a helpful construct. It points to the mutually constitutive relationship between organizational understanding and routines (Rerup & Feldman, 2011). The similarities between meaning structures provides insights on the relation between routines and how these express and draw on a specific organizational understanding.

4.5 Summary and the open issue of relating meaning structures

This chapter is on the improbability of pluralistic organizations. We know that a hospital is characterized by different worlds, diverse understandings and interests, knowledge-intensive work, and ambiguous power relations. Plurality often leads to conflict, incoherence, and misunderstanding. Thus, pluralistic organizations problematize stability and coherence. The paradox lens argues that the sub-systems are independent and inter-dependent and that the subsystems may be internally coherent but paradoxical when they adjoin. Exploring these sub-systems (e.g., clinics or departments) with routine dynamics to depict the plurality of meaning structures focused on the research question: How does a pluralistic organization generate a paradox?

The description and the comparison of the different clinics and departments as meaning structures leads to a theoretical understanding that meaning structures reproduce themselves endogenously and lead to a paradox as they adjoin. Surgery makes sense within surgery, inner medicine within inner medicine, and nursing within nursing. According to their respective meaning structure, they conduct an organizational task like integrating the respective clinics or department different from one another but in line with their meaning structure.

These findings first highlight the different, and in part incompatible, ways of acting between meaning structures. These differences address the improbability of a specific pluralistic organization and thereby provide empirical insights to the assumption that paradoxes are integral to organizations. Second, the similarities between the meaning structures reveal three patterns on how they reproduce themselves endogenously, thus shedding light on how a paradox persists within the organization. This paradox is marked by the poles of differentiation and integration. Differentiation resonates with the plurality of meaning structures, while integration becomes relevant with organizational issues that span the boundaries of the meaning structures. Third, I argue that this paradox is foundational to the studied pluralistic organization.

This chapter provides an empirically nuanced view on how a paradox is actively generated and continuously accomplished. In comparison, the general definition of paradox bears the risk of taking the poles as entities, whereas this chapter contributes to a processual perspective on paradoxes. Paradoxes are active accomplishments just like the organization they characterize. Building on these insights, my study extends from the top management team to the organization. It also complements the insights on the dynamic effects between paradoxes by demonstrating how a paradox is generated. Furthermore, the chapter speaks to routine literature. Extending to a pluralistic setting evokes the distinction between different types of routines that in turn enables to depict the relation between them. These relations and routines enact the organizational understanding and stabilize a specific meaning structure.

The insights of this chapter advance on how a pluralistic organization reproduces its plurality which manifests in the paradox of differentiation and integration. The explanation so far does not yet illuminate in what ways the organization deals with its plurality and prevents itself from disintegration or paralysis. In the next chapter, I

explore how a pluralistic organization handles the paradox of differentiation and integration prior to the paradox's salience. I aim for insights on how a pluralistic organization like a hospital achieves its continuity or stability in light of this paradox, the capacity which Kraatz & Block (2008: 257) suggests being "somewhat of a mystery".

5 The coordinating routine: Handling the paradox and achieving latency

"With continued research, perhaps we can discover how organizations pull themselves out of the self-made quagmires by their own bootstraps." (Putnam, 1986: 166)

My second research interest is on how a pluralistic organization such as a hospital accomplishes itself in light of the founding paradox of differentiation and integration. This research interest is triggered by the observation in the literature that pluralistic organizations often appear impermeable to deliberate change initiatives. The impermeability suggests that a hospital is remarkably stable to interventions.

Paradox literature helps to explain the impermeability in so far as the organizational members tend to interpret deliberate change attempts from their meaning structures that express the different sub-systems with which they associate. The paradox literature hardly addresses how an organization accomplishes its stability in light of a foundational paradox that is integral to the organization. Rather, studies embark on a salient paradox that invites deliberately acting upon it (Beech et al., 2004). Before its salience, a paradox is said to be latent, which is an important assumption for the paradox lens (Lewis & Smith, 2014; Smith & Lewis, 2011). But, this assumption still has not been researched sufficiently. Building on the insight that opposing poles relate prior to their salience (Clegg et al., 2002), I focus on the relation between the poles as the prior enacted solution that accomplishes paradox latency with the second research question: How does a pluralistic organization handle a paradox and accomplish its latency?

In this chapter, I explore how the paradox of differentiation and integration is handled within this organization. The stream of routine dynamics on coordinating routines provides the analytic guide. My results show a coordinating routine that relates the opposing poles of differentiation and integration and achieves paradox latency.

In the following chapter and first, I briefly recount the hospital integration. Second, I present and analyze in detail the board members' discussions of undecided issues. These issues illustrate moments of paradox salience. Their discussion in the board exemplifies the accomplishment of paradox latency by shifting the issue to private conversations, to a project, or by diluting the issue.

Third, the analysis starts with elaborating on the background assumption of mutually granted autonomy, which exemplifies the paradox of differentiation and integration. The paradox manifests in the perceived role of the executive board as a non-decisive body. As an alternative to the executive board, the practitioners enact a routine they call "bilateralism" that unfolds the paradox. Enacting this routine involves shifting conflictual issues outside the executive board, thereby accomplishing paradox latency therein. At the same time, the paradox is salient to the board's individual members. The analysis concludes with a theoretical model. The model proposes that the paradox of differentiation and integration forms a duality with the coordinating routine of bilateralism and achieves paradox latency.

Fourth, I discuss these insights with the literature. First, the coordinating routine provides a both-and solution to the paradox that emerged from local practice. Second, the insights illuminate on the under-researched assumption of paradox latency by showing that latency is an active accomplishment; that latency requires a nuanced view in terms of whether it applies individually or collectively; and that the paradox and the coordinating routine form a duality that fosters the stability of a specific organization. This duality does not rely on an overarching meaning structure of the hospital as whole. Rather, it resonates with the different meaning structures by acknowledging and reproducing the mutually held assumption of relative autonomy between the different meaning structures. Third, my insights of this chapter also speak to routine literature on the topic of relating different meaning structures.

5.1 Results: Achieving paradox latency

The following section summarizes the events of integrating Reho into Laho before attending to the executive board's discussion on certain incidences to display the salience of the paradox and the accomplishment of paradox latency.

5.1.1 The hospital integration as an emergent dynamic process

The integration of Reho into Laho exemplifies how an organization-wide issue evolves. At the end, the hospital region is called Laho, a hospital with two sites. In fall 2005, Hank, the CEO of Laho, reflects on the dynamic process in a research interview: "I

always maneuvered toward the vision I have in the back of my head. And like sailing on the lake you have to go with the wind and make detours in order to reach your destination."

As described in more detail in chapter 3 (see section 3.2.1., p. 59ff.), the hospital integration begins in 1998 after the cantonal government owning the hospitals withdraws his previously announced closure of Reho. The CEOs of Reho and Laho, Martin and Hank, decide to cooperate more closely. They initiate a project team that integrates the departments of technical support and IT (2000), the emergency care units (2002), gynecology (2004), and the pharmacies (2006) of Reho into Laho. Meanwhile, on January 1, 2003, the cantonal government announces the *hospital region* of Reho and Laho. In 2007, the executive board of the hospital region publishes the new name of the hospital region on January 1 and an organization chart at the end of that same year. During my field phase from 2004 until 2006, the hospital integration is a regular agenda topic on the executive board's meetings and bi-annual retreats that are reported in the subsequent sections. In the annual report of 2007, published in March 2008, the hospital management calls the integration successfully completed and suggests a planned design oriented towards the motto of "one hospital - two sites". During a meeting with clinic heads, Hank, Laho's CEO, states: "Johannes argues that the integration with Reho was unclear. That is not correct. We had a well-defined concept of interlocking the different disciplines individually. This was an open and fair procedure. While we closed some units at Reho, we simultaneously secured its future."

As reported in chapter 4, the surgery (p. 80f.), the inner medicine (p. 85f.), and the nursing (p. 91ff.) departments engage in the integration between 2002 and 2007 in their own ways. With internal medicine integrated in 2007, the executive board of the hospital region declares the "integration complete". The yearly report (March 2008) adapts the surgeons' slogan to "One hospital – two sites" to describe the overall idea.

In line with the CEO's initial sailing image, the unfolding events suggest that the integration is an emergent process rather than one that was pre-planned by the executive board. The process expresses that the executive board grants the initiative and expects it from the clinics and departments, acknowledging their respective autonomy. Each conducted the integration in its own way by responding to different triggers with

different durations and ways of integrating. In retrospect, the executive board defines the organizational structure and the new name for the hospital region and declares it a success.

5.1.2 Achieving paradox latency in the executive board

The dynamic of the hospital integration manifests itself in several incidences, particularly between the fall of 2004 and the beginning of 2005. During this time, the integration of nursing unfolds, while surgery had declared its successful completion, and inner medicine appeared hardly active. The following section depicts four of the issues that turned up in the board away-days in November 2004 and January 2005. The issues exemplify different ways of handling the paradox within the executive board.

First, the decision of replacing the nursing director at Reho turns into a dispute between Laho's nursing director and Reho's CEO that shifts to a private conversation between the two. Second, the open issue of Reho's status within Laho's organizational structure transfers to a project; this pattern also occurred in the discussion of the hospital's strategic positioning. Third, the executive board addresses the surgeons' Adipositas project at Reho. The project interferes with inner medicine and impacts the integration process. It triggers the call to develop explicit rules to clarify the relation among clinics and with the executive board.

The executive board's engagement with these issues shows how they enter and exit the executive board without being resolved. The shift to a private conversation or to a project and the dilution of the issue show how the paradox latency is accomplished within the executive board. Each incident is presented by introducing its context, displaying the board's conversation, and analytically summarizing it by highlighting the salience of paradox and its latency within the executive board.

5.1.2.1 Transferring the issue of replacing Reho's nursing director to a private discussion

The first incident moves to the private conversation between the involved board members (Table 5-1). The excerpt takes place during the board's away-day on November 26, 2004. While extensively discussing the situation and progress of integrating Reho into Laho, Nada (nursing director at Laho) and Martin (CEO of Reho) dispute their prior agreement to replace Reho's nursing director. In excerpt 1, they argue about the role of Reho's prior nursing director under the incoming one.

Board member	1st order construct (discussion excerpt)	2nd order concept	Aggregate dimension
Nada, nursing director	Currently, we achieved that Rachel will become the nursing director at Reho starting February 1st, 2005. And Hector, the current nursing director, will have different tasks.	Raising the issue	Paradox salience
Martin, CEO of Reho	However, he will be her representative.	Disputing	
Nada, nursing director	But only, when Rachel is absent …		
Martin, CEO of Reho	Is that not the same?		
Nada, nursing director	No way! We are currently developing a representative for Rachel. … This decision was a long, good process in accordance with the Reho nurses. We developed all the necessary conditions on all levels for it, Martin. But let us continue to talk in private about this issue.	Shifting the issue to the bilateral conversation	Achieving latency
Hank, CEO of Laho	Hank continues his presentation and names the upcoming projects within the context of the hospital integration, like that of Adipositas, or the day clinic for chemotherapy.	Not engaging in the issue	
Nada, nursing director	Nada turns to me sitting next to her and comments angrily: ”Such a topic does not belong here into the public of the board. Things like this have to be handled in private.”	Incommunicability of the issue	

Table 5-1: Excerpt 1: shifting the issue to bilateral conversations

This excerpt illustrates how a conflictual topic shifts from the executive board to the private conversation between the involved parties. The issue of replacing the nursing director expresses the relation between Laho’s nursing and Reho’s hospital management, which was an unresolved issue at the time (see following incident). The disputed topic is returned from the “public” sphere of the executive board back to the private sphere of private conversation. Less obvious is the actions of the attendants that are difficult to display. They remain silent and do not engage in the dispute. Likewise, Hank continues his presentation. The topic exits the executive board.

As an empirical interpretation, this silence associates with what respondents call the “desire for harmony” within garden thinking (see Table 4-1, p. 94). No one enters the domain of Nada and Martin but refrains from engaging in their conflict. Torsten, head of anesthesiology, said: “There is a strong desire for harmony. Here at Laho, you try to avoid interfering with someone else’s domain, and rather try to stay in harmony with one another. That is also part of the garden thinking.”

Shifting conflictual issues from a meeting to a private conversation appears to be typical at Laho for organization-wide issues. First, Pablo, the head of emergency care, describes the procedure of generating support to install the position of a clinical head for his unit. It required bilateral conversations with every clinic head: ”It took a lot of talking to

every single clinic head for an hour or two each. And sometimes, the clinic heads just wanted to place their wishes and worries, but without concessions on their part."

Second, as a variation, Robin first engages the subordinates of clinic heads who are concerned with the issue in question in their daily work. "I have to sell the clinics a revision of our financial controlling system which they generally refuse. It is really difficult to get the surgeons and the internists into this same boat. You have to circle around and around so that it fits, and that takes a lot of time … I get the senior physicians and leading doctors into a working group because they run the wards. After they understand the benefits for their own work in the clinics, I approach their superior."

Third, Hank, the CEO, describes the importance of private conversations prior to entering an issue in the executive board. His example is a centralized handling of the hospital's bed capacity: "Bed capacity is a hot issue. You only have a change with it, when talking to every clinic had in private first. If you approach them jointly, you get a collective 'no'. I talk with them one-by-one about the possibilities, their worries and how to handle them. I thus sense where the resistance may come from and where I might have support. Only after this preparatory work do we have a joint meeting where I will discuss the give-and-take for every clinic that comes along with coordinating our bed capacity centrally." These examples suggest that shifting potentially conflictual or "*hot*" issues (Hank) to private conversations is a typical pattern at Laho.

5.1.2.2 Subsuming the issue of hospital relation under the emergency project

As a variation to the transfer to private conversations, the following excerpt (Table 5-2) shows how a conflictual issue shifts from the executive board to a project while enlarging its scope. In the following excerpt of the board's away-day November 27 2004, Robin raises the issue of clarifying the status of Reho in relation to the existing departmental structure of Laho. While Hank explains the ambiguity of this issue in terms of the external context, he appreciates Caitlin's suggestion to transfer the topic to a project that ends the discussion.

Board member	1st order construct (discussion excerpt)	2nd order concept	Aggregate dimension
Robin, head of finances	I suggest that we do not speak of Reho as a hospital anymore but instead that we refer to it as a department. Therefore, it should say "Department Reho", not hospital.	Raising the issue	Paradox salience
Hank, CEO of Laho	That is correct when you look to the inside. Within our structure, Reho is a department. But to the outside and for the people in town it is still a hospital. In addition, with the hospital region, we should call it a hospital when externally referring to Reho. Otherwise, people get nervous again fearing that it loses its status of a hospital	Enlarging the issue's context	Paradox latency
Caitlin, head of gastroenterology	Well, we could use the emergency care as an example. There we have to offer a local service at Reho, but it is operated centrally from Laho and coordinated from there.	Transfer of the issue to a project	
Hank, CEO of Laho	That is a good idea. Let us transfer the issue to that project to clarify the relation between Reho and Laho along the lines of emergency care		
	End of discussion		

Table 5-2: Excerpt 2: shifting the issue to a project after enlarging its scope

The executive board hardly takes up this issue. After Hank enlarges its scope by referring it to the context outside of Reho the issue shifts into the project of reorganizing the region's emergency service. The board thereby avoids discussing the issue that involves the relation between the two hospitals; thus, they express the paradox of differentiation and integration. The paradox sinks into latency, as the issue is unresolved.

Nada, the nursing director, comments shortly after the above observation: "It has never been clarified who is responsible for what and which hospital offers which services and what should we do jointly. Instead, we have a lot of 'good-will' projects that fiddle around with the topics. But, the executive board has not clearly defined what the overall organization looks like, and what the relations between the departments, the clinics and the executive board is like." The status of Reho within Laho is finalized after the clinics and departments declare their integration complete, which was two years later.

Interview respondents depict the shifting of an organization-wide issue to a project as a typical pattern within Laho. A first example reports Damian, the head of interdisciplinary medical services department, who explains how hospital management aimed to introduce process management along these lines (see appendix 8.4, p. 215): "To avoid disruptions, we subsume the process orientation under an information technology initiative and ask: how can we improve work processes through electronic devices? There, everyone thinks, 'wow, that's great, let's do it!' The idea behind it is of course a little bit different. But you have no chance if you want to sell the idea of process management directly." Hank, CEO of Laho repeats this pattern of subsuming the

initiative under the revised employment law in 2006 (Merz, 2010). With the new law, the hospitals have to restrict the work hours of their assistant medical doctors. This resource restriction opens the possibility to subsume the topic of process orientation under the implementation of the employment law. Hank, the CEO of Laho, comments: "In the executive board, we knew that just telling the clinic heads to optimize their processes would not work. They just do not think in processes. At the same time, we need this thinking in the future. This is why we used the employment law initiative to place the topic of processes in the hospital."

A second and more extended example occurs within the board's away-day on January 28, 2005 (Table 5-3). It concerns the overall strategic position of the hospital that has not been developed within the executive board but within a project team working on a proposal for revising Laho's buildings. This issue's handling exemplifies a similar way of transferring a conflictual issue into a project while enlarging its scope. Prepared by the project team (mainly board members), the presentation displays a list of 13 future images of different units. During the presentation, Robin, who sits next to me, comments: "All these individual snapshots of the parts drive me mad. We lose sight of the overall hospital and miss out on what all these single strategies mean for the whole." The issue enters the board's discussion as Hank invites Johannes, a researcher, to comment:

Board member	1st order construct	2nd order concept	Aggregate dimension
Johannes, researching university professor	I would suggest creating an idea of the overall future hospital in which the inter-dependency of these different units becomes visible. This may help to identify important issues for decision while providing a background for the decision-criteria you want to apply.	Raising the issue of the whole by an external	Salience of the paradox in the board
Pablo, member of the project team (head of the emergency unit)	For me these decision criteria are the number of treatments, the cost development, but also I find the implication for professional training of medical doctors relevant. …	Responding to the issue	
Hank, CEO of Laho	What interests me right now is the timing. When do we pursue which part in developing our hospital into the future? How do all these projects on the different parts play together on a time scale? What I would now like the group to develop is an action-oriented plan on how we proceed to make these images real.	Reframing the issue on a temporal scale	
Gustav, president of the board of directors	I think we should define the future hospital image based on the patient processes. From there, we could develop alternatives and select the one that appears best to us.	Returning to the issue of the whole	
Consultant, who is hired to assist the project team	Thank you very much; we will do this in the project team.	Transferring the issue into the project team	Achieving paradox latency in the board
Hank, CEO of Laho	What I do not want is that the project team turns into some kind of closed shop, an elite group that determines the future of our hospital. I want that those affected by the	Enlarging the scope and calling to refrain	

Board member	1st order construct	2nd order concept	Aggregate dimension
	future image will be included. I want an iterative process of including them and further developing the whole image with its implications for the buildings. The results need to remain open to change up to the last moment.	from fixation	
Nada member of the project team (nursing director)	Hank, the problem is that the group then becomes too large to work with, but it remains too small to include all the viewpoints in this hospital. The current organization of our team is difficult. Just coordinating meeting times is already a daunting task.	Impracticability of enlarged scope	Achieving paradox latency presumably also in the project team
Caitlin, member of the project team (head of gastroenterology)	I find it important that possibly all will be included in this process. In addition, the different support departments and the second layer of leading doctors who then actually do most of the work within the clinics.	Further enlarging the scope	
Hank, CEO of Laho	We cannot overstretch it. I would involve the clinic heads, but not the others. But we really need to start and have an action plan on how to proceed. Once the building process is under way, there will be the meat on the bones that gives as a more concise picture.	Limiting the enlargement; restating to refrain from early fixation	
End	At this point, the discussion ends and the members engage in informal conversations during the coffee break	No conclusion	
Meeting minutes	The official minutes to the meeting highlight that the executive board "took notice of 13 business concepts" of the different clinics and departments, however without referencing the above discussion regarding the relation of these parts to the whole (minutes 03.02.06, pp. 6ff)		

Table 5-3: Excerpt 3: shifting the issue into a project and enlarging its scope

These examples of shifting the undefined relation between Reho and Laho, the process optimization, or the strategic positioning to a project suggest the transfer as a typical pattern at Laho. The issue exits the executive board and does not enter the official meeting minutes. Furthermore, by enlarging the scope of the issue, it risks dilution when working further on the issue. This risk is prominent in the second excerpt, while it is more implicit in the first one. In summary, the potential salience of the paradox returns to paradox latency within the executive board by transferring the issue to a project and by enlarging its scope.

5.1.2.3 Diluting the call for defining explicit rules in the Adipositas issue

The fourth excerpt provides a rare occasion in which the autonomy of clinics is challenged within the executive board (Table 5-4). This time, the issue does not shift to a project or to private conversations but remains in discussion between the board members. The excerpt also refers to the role of the executive in relation to the clinics and departments. At the end, the issue dilutes without an entry in the official minutes.

The issue is the initiative of "Adipositas" pursued by John, the head of surgery. The "Adipositas" initiative involves a new treatment area for obese patients planned to be located at Reho. Besides surgical therapies, the Adipositas project includes a strong

focus on treatment and therapeutic measures to help patients balance their weight. Therefore, the project interferes both with inner medicine and with the integration process of the hospitals. The topic arises after Martin, the CEO of Reho, finishes his presentation of the upcoming initiatives at Reho to the executive board of Laho:

Board member	1st order construct	2nd order concept	Aggregate dimension
Caitlin, head of gastro-enterology	For me, Adipositas leans too strongly towards surgery. I suggest a more interdisciplinary approach. You need general practitioners for this kind of treatment, who are internists. In addition, they should be firmly embedded in their home discipline also to ensure their further training.	Articulating the breach in garden thinking	Paradox salience
Martin, CEO of Reho	Sure. However, my question is how do we proceed with Reho? Perkins, the head of inner medicine retires in two years. How do we continue from then on? Where are the areas of treatment that surgery, orthopedics and inner medicine host at Laho and which ones do we have at Reho?	Enlarging the scope and raising the general issue	
Hank, CEO of Laho	This question surely is an allegation against us. But John, the head surgeon, causes this fait accompli of Adipositas. We conducted the process badly, but not with bad intentions.	Return to the issue	
Martin, CEO of Reho	Adipositas heavily depends on the clinic head. For Adipositas, we need infrastructure and equipment, because there are patients with 150 up to 300 kilos. We need different beds for them and a different infrastructure.	Questioning the location medically	
Torsten, head of anesthe-siology	I would not conduct surgeries on those patients at Reho. I would not install a center at Reho for this kind of treatment.		
Martin, CEO of Reho	I have to give you a private lesson, Torsten. We are not two hospitals, but one with two sites. It is thus irrelevant where the after treatment takes place. You really have to let these larger dimensions of the hospital region enter your thinking.		
Torsten, head of anesthe-siology	Still, I would not conduct such surgeries at Reho. You cannot do 200kg-surgeries there.		
Hank, CEO of Laho	In principle, I say that a clinic head develops his strategy. If the strategy requires many resources, we have to place the topic here in the board. Nevertheless, we are one hospital.	Attempt to clarify the relation between clinic and board	Garden thinking
Gustav, president of the board of directors	Where is the instruction by the executive board or by the board of directors for the Adipositas project? I find it unsatisfactory that a clinic can start something and then just informs the executive board. That creates problems. Who is responsible to tell John what he can do and what not?	Raising the issue of decision-making authority	Salience of paradox
Hank, CEO of Laho	The answer to this question is clear to me. Telling him is a topic for the executive board as a whole.	Placing the issue in the board	Attempt to strengthen the whole
Gustav, president of the board of directors	We have to define explicit rules of the game here, like a clear distinction what belongs to Laho as the center hospital and to Reho as the periphery. We need such rules of the game that also apply to clinic heads.		
Hank, CEO of Laho	Well, the whole integration is a tremendous learning process. We have to build on our successes there. With issues like Adipositas, we have to ask ourselves, how are we going to handle them?	Reframing the issue as learning, focus on success	
Sebastian, head of the OHN clinic	I appreciate this notion of the integration as a learning process, also within the executive board, and for the CEO as well. In general, I suggest having an initiative like Adipositas to be discussed here, but not decided here.	Refraining from responsibility	
Hank, CEO of	I agree that also the CEO can learn here. However, there is a	Asking for	

Board member	1st order construct	2nd order concept	Aggregate dimension
Laho	general tension. Handling John is not simple. In addition, I see you as clinic heads responsible because you can talk to him on a professional level whether Adipositas belongs to surgery or not. I would appreciate more support from your side in this.	board members to support the view of the whole	
Gustav, president of the board of directors	I think John cannot treat us like this, with just going for Adipositas and merely informing us once it is under way. We have to have some rules of the game here: who is doing what? In addition, if that is beneficial for the whole hospital, then we can go for it. On other topics, Reho has been also a good example.	Re-proposing the issue	
Martin, CEO of Reho	In my view, the general problem is the interdisciplinary collaboration. Strengthening that is the task of the executive board. Moreover, it is very hard to discipline Reho with all the parallel initiatives in different departments and clinics. In addition, we have to remember the political dimension, after we had the looming closure of Reho and the public demonstrations with the petition signed by 70000 citizens to keep Reho.	Refraining from responsibility and enlarging the context	Reframing and accepting the current situation
	End of the discussion.		
	The topic does not enter the minutes.		

Table 5-4: Excerpt 4: struggling with the paradox without altering its handling

In this excerpt, the paradox of differentiation and integration becomes salient in two ways. On the one hand, board members note that Adipositas breaches the boundaries between inner medicine and surgery, spurring the open conflict between Torsten and Martin. On the other hand, Gustav, the president of the board of directors, criticizes John's bypassing the board in the decision on Adipositas. For the board, the paradoxical challenge is to allow for the clinics' initiative but to also embed it into the overall hospital region. Gustav questions the otherwise granted autonomy to the clinics and departments. He proposes to define explicit rules that clarify the tasks and responsibilities between clinics and the executive board.

During the conversation, the executive board discusses its role in relation to the clinics. Mike reproduces the general understanding of the executive board, when suggesting that such an initiative should be "discussed here, but not decided here" (see Table 5-5, p. 130). He thereby responds to the CEO's invitation to discuss "how to handle this issue" of John bypassing the executive board. Insisting on the topic, Hank explicitly asks the medical board members to engage as medical professionals with the head of surgery and critiques the board's lack of support. The board members do not respond to this comment. Rather, Martin the head of Reho who accepted Adipositas at his site justifies the surgical initiative by referencing the historical context of Reho and concludes that Reho is "hard to discipline". His comment of enlarging the scope to a general statement concludes the discussion. The issue is not pursued further, and the discussion moves on

to the next topic. The paradox of differentiation and integration came to the fore in the two forms of relations between medical disciplines and of relating the board to the clinic. The paradox of differentiation and integration sinks back into latency and exits the board's attention. In a later interview, Nada, the nursing director, further explains that involving the executive board on an initiative like Adipositas would jeopardize the entire project: "Adipositas would not go ahead if it passes through the executive board. There, you have to discuss it extensively and that can be a killer to motivation. … And now, it is going to work." The clinic of surgery starts the Adipositas center at Reho in spring 2005.

On the one hand, the Adipositas initiative is typical for Laho. Similar to the examples of revising the controlling system, introducing a centralized coordination of bed capacity, or establishing the position of the clinic head in emergency care, the Adipositas project generates commitment through a private conversation presumably between John and Martin. In addition, the executive board appears familiar with diluting an issue. While the executive board developed a strategy report requested by the canton's government during the summer of 2004, we observed the following pattern: During the executive board workshops in the strategy report several issues occurred that were critical to a respective clinic or department, for example the proposed focus on certain treatment areas rather than others. The board member who perceived to be negatively affected by such a focus raised his concern. His colleagues replied by reassuring him that such a content was included for the public owner but without internal relevance. As such incidents accumulated over time, the strategy report lost internal significance despite the resources invested into its development.

On the other hand, the discussion of the Adipositas project provides a rare example of the board explicitly turning to the relation among the clinics and the executive board. With this discussion, the paradox of differentiation and integration becomes salient within the executive board. Often, such conflictual issues remain hard to communicate despite the desire to do so (see also Table 5-7, p. 136). The board members do not seem eager to move the issue of Adipositas forward in a way that explicates the relation between clinics and with the executive board.

5.2 Analysis: Paradox latency as an active accomplishment

The four excerpts show how the executive board performs the handling of the paradox of differentiation and integration. Conflictual and open issues like the ones mentioned become a topic and thereby make the paradox of differentiation and integration salient. Engaging with these topics is brief and shows how paradox latency is accomplished within the executive board. First, the issue shifts to the bilateral conversation between the disputing parties. Second, a conflictual issue shifts into a project while enlarging its scope. Third, paradox latency occurs by diluting the topic. All four incidents display the salience of the paradox and how it returns to latency. The incidents demonstrate that and how the executive board achieves paradox latency collectively.

The following sections elaborate on the background of the excerpts. First, I explicate the mutually held assumption of the clinics' and departments' autonomy at Laho. It fosters and impedes the hospital integration. This mutually held expectation points out the paradox of differentiation and integration. Second, this paradox is expressed in how the members consider the executive board as an amalgamation of partial interests but not as the space to move organization-wide issues forward. Third, I explain the informal routine of "bilateralism". It serves as the enacted solution to the paradox of differentiation and integration alternative to the executive board. Fourth, the paradox becomes latent in the executive board but is salient to its members. I summarize the analysis by concluding that bilateralism and the granted autonomy form a duality that stabilizes this hospital.

5.2.1 Mutually granted autonomy enables and impedes integration

At Laho, the clinics and departments mutually expect autonomy. Gustav, the president of the directors' board, summarizes: "the clinics run themselves". Likewise, Hank, the CEO (see Table 4-1, 94), explains "The issues must originate from the units. You cannot just tell clinics top-down or from outside: 'You have to do it!'"

Granting autonomy to clinics and departments adheres to the specialized expertise of each clinic and their knowledge-intensive work. Gabriel, the head of organization and infrastructure, explains: "They [the clinic heads] have to develop their specialty so that they continue to be successful." Accordingly, the executive board calls for and allows the clinics and departments to pursue their respective integration in their own way.

At the same time, the presented excerpts illustrate the downside of the granted autonomy. It also inhibits the integration of different initiatives and projects (see Table 4-2, p.96). Under the mutually held expectation of autonomy, it becomes difficult to devise a general understanding of how the clinics relate with one another or with the board, how issues between Reho and Laho's nursing department are to be resolved, or what the status of Reho looks like within the departments of Laho. Likewise, devising the strategy of Laho appears to remain on the level of the different clinic and departmental strategic orientations without moving such an issue towards the overall level of a hospital-wide strategic positioning.

5.2.2 The executive board as a non-decisive mixture of partial interests

In line with the mutual expectation of autonomy, the executive board members do not consider it as the space for deciding on organization-wide issues, despite its official role: "The official version is that the executive board bundles all these different partial interests" (Robin, the head of finance). In practice, the executive board appears to its members more of a collection of particular interests. The following Table 5-5 contains observations of the members on their executive board:

Interview Partner	1st order construct	2nd order concept	Aggregate dimension
Nada, nursing director	All members wear two hats, if you want to say it that way. They have to look after their own department; and at the same time, we are responsible for the entire hospital	Double role of members	Mirror of differentiation
Caitlin, head of gastroenterology	We are all wearing two hats, and everyone knows this. It becomes a bit difficult then.		
Torsten, head of anesthesiology	Reflects on the away-day in which we validated bilateralism: „Well, in the board, everyone talks strategically with his own agenda in mind."		
Gabriel, head of organization and infrastructure	The challenge for the members of the board is the following: 'do I think now for the whole hospital or do I think for myself and my clinic? Is it better to push my pet project or do I pursue the overall benefit?'	Oscillating between the part and the whole	
Robin, head of finances	The official version is that the executive board bundles all these different partial interests. Everyone will tell you that.	bundling the separate interests	
John, head surgeon	In the end, the executive board represents individual interests.	Partial interests	
Gabriel, head of organization and infrastructure	I believe that it is important for the executive board to draw on a broad base of preferably all the different views and interests. If we had a single person at the top it would not work. The air up there is very thin, and he would be very lonely. Thus, the broad support is essential, but it does not mean that someone needs to take decisions.	Representation of interests No decisions in the board	Hardly a decision-making body
John, head surgeon	A decision-making body with ten people cannot decide. And therefore it does not decide anything. Because everyone looks after his own garden	No decisions in the board	

Interview Partner	1st order construct	2nd order concept	Aggregate dimension
Sebastian, head of OHN	The board meetings are supposed to serve the legitimization of issues and projects, but not the place of defining strategies.	A body to legitimize decisions officially	
Robin, head of finances	But, you cannot compare this executive board with one you find in private companies, the one I was a member before coming here. Where I was before, the board had the right to coercively define what was to be done. Such a right does not exist here, not even slightly. You cannot tell the clinics or departments what to do. That does not work.	You cannot tell the clinics what to do	
Hank, CEO of Laho	In my view, it is a sounding board. When we try to do something for the hospital as a whole, I can sense here how the different clinics and departments may react and whether the time is right for an initiative or not."	Body to sound ideas	

Table 5-5: Role of the executive board according to its members

From a member's perspective, their function implies a double role: "All members wear two hats, if you want to say it that way. They have to look after their own department; and at the same time, we are responsible for the entire hospital" (Nada, nursing director). The reference to the "two hats" points out the paradox of differentiation and integration as experienced on the individual level. Gabriel, the head of infrastructure, summarizes the challenge of the executive board: "The challenge for the members of the board is the following: 'do I think now for the whole hospital or do I think for myself and my clinic? Is it better to push my pet project or do I pursue the overall benefit?' Of course in the board we first have to think in terms of the entire hospital. But that is not so often the case for the clinic heads."

Hank, the CEO of Laho, views the executive board as a "sounding board": "In my view, it is a sounding board. When we try to do something for the hospital as a whole, I can sense here how the different clinics and departments may react and whether the time is right for an initiative or not." Accordingly, non-members, like John, the head of surgery, do not consider the board as a decision-making body: "A decision-making body with ten people cannot decide. And therefore it does not decide anything. Because everyone looks after his own garden" Other clinic heads, like Sebastian, see the board as the locus of legitimizing decisions formally: "The board meetings are supposed to serve the legitimization of issues and projects, but not the place of defining strategies."

In summary, the members of the executive board do not consider the board as the space to decide on organization-wide issues. The four excerpts illustrate how conflictual organization-wide issues exit the executive board. Within the board, its members refrain from interfering with someone else's domain.

5.2.3 Bilateralism as a routine to handle the foundational paradox

As an alternative to the executive board, organization-wide issues are moved forward by an informal routine. The organizational members call it "bilateralism". It provides the way through which they move an issue forward that spans the clinics' and departments' boundaries: "The bilateralism is very formative here. Everybody looks with whom he can push something" (Nada, nursing director). The Table 5-6 provides interview excerpts on bilateralism coded to the analytical categories of who becomes involved on what, how, and when. A description of bilateralism follows the table.

Interview partner	1st order construct	2nd order concept	Aggregate dimension
Hank, CEO of the hospital region	The issues must originate from the units. You cannot just tell clinics top-down or from outside: 'You have to do it!' Instead, a topic must originate bottom-up. It needs to address the clinics' demands. And with some incentives for enhancing collaboration you can move it forward, and coordinate it from the top. But in essence, topics need to grow from the bottom.	Topics require to be driven by the clinics	Who and what of the routine
Nada, nursing director	Many issues are handled bilaterally. If you have to incorporate all the different opinions you lose momentum. When I think of some clinic heads, they act like lightning. 'I want it, and I want it right away'. Then they are active and really do a lot. But placing their topic in the public so that everybody else contributes his opinion may kill the motivation."	Topics emerge from the clinics and are pursued bilaterally	Who and how of the routine
Pablo, head of emergency care	It took a lot talking to every single clinic head for an hour or two each. And sometimes, the clinic head just wanted to place their wishes and worries, but without concessions on their part.	Bilateralism takes time and invites wish-lists	
Hank, CEO	Hank, Laho's CEO, develops the issue of establishing a centralized handling of patient bed capacity across the clinics: "Bed capacity is a hot issue. You only have a change with it, when talking to every clinic had in private first. If you approach them jointly, you get a collective 'no'. I talk with them one-by-one about the possibilities, their worries and how to handle them. I thus sense where the resistance may come from and where I might have support. Only after this preparatory work do we have a joint meeting where I will discuss the give-and-take for every clinic that comes along with coordinating our bed capacity centrally."	Reaching individual agreements before entering a collective setting	
Robin, head of finances	Here, I have to sell the clinics a revision of our financial controlling system which they generally refuse. It is really difficult to get the surgeons and the internists into this single boat. You have to circle around and around so that it fits, and that takes a lot of time … I get the senior physicians and leading doctors into a working group because they run the wards on the shop floor. After they understand the benefits for their own work in the clinics, I approach their superior.	Reaching agreement with those with a concern	
Gustav, president of the board of directors	The clinics run themselves. With their high degree of inter-relations and with their continued high autonomy, a lot of issues go through the informal networks of personal relations between the clinics.	Informal networks	
Nada, nursing director	The surgical Adipositas center – if this project had taken the way over the hospital management, it would have been killed. But it has been initiated and introduced via bilateral discussions and agreements. And now it works and nobody will say anything." (NM, 585, 599)	Moving topics forward with bilateralism	How of the routine

Interview partner	1st order construct	2nd order concept	Aggregate dimension
Nada, nursing director	"Well, you steal your neighbor's apples (laughs). No, no, it is also like this: you would also borrow the lawn-mower, and you would water the other's plants and trim his roses. Well, garden means: you need someone to take care when you are away. And that happens as well."	Collaboration on one-on-one	
Pablo, head of emergency care	You have to be tough but also diplomatic. You must know that the shortest path between two points is not a straight line. You need to keep your goal in your own view and then look how to reach it, without losing too much along the way. But if you are just tough and tell the others: 'That's it, that is what I want and that is what I do not want' You do not get anywhere. In principle, you have to be like a gas. I mean you have to bend, but a gas does not break.	Reaching agreements	
Hank, CEO	With the integration, Johannes and you criticized that we lacked a clear concept and transparent plan. Looking at it from the organizational view, I agree. But, I always maneuvered toward the vision I have in the back of my head. And like sailing on a lake you have to go with the wind and make detours at times in order to reach your destination. Look, Harald, the politicians praise us for the integration, because there was no public uprising, the doctors remained quiet and are satisfied now. The integration is widely accepted and I need this support to really do something	Achieving accepted results	Why of the routine
Nada, nursing director	We will need some time until biological solutions kick in … but then, I think, we clearly have to address this change. But for the time being it works. After all, we are not a turnaround case. It works with some pains we can handle	Bilateralism works	
Nada, nursing director	The bilateralism is very formative here. Everybody looks with whom he can push something	informal networks	

Table 5-6: Bilateralism

Nada points out that "bilateralism" means that any clinic or department head detects potential partners for the issue in question: "Well, everyone looks with who can I push my topic. And then you continue from there." Likewise, Robin, the head of finances, explains: "you cannot plan your steps in a logical sequence and believe that it works like that. Instead you have to look at who do I need to incorporate? What is the network I need to build? And then you have to push the topic with these people." Gustav, the president of the board of directors, adds that these networks are informal and their working hard to grasp for an outsider: "Personally, I believe that the clinics discuss the topics among themselves, and that is done in private one-on-one conversations. … And you cannot really see how that works in detail."

Bilateralism is a means to generate support by involving the clinic or department heads through private conversations. The given examples are the establishment of the position as head of emergency, the revision of the controlling system at Laho, and the centralization of handling bed capacity. These issues span the boundaries of clinics and

departments, and the actors pursue them by private conversations first. “Only after this preparatory work do we have a joint meeting”, notes Hank, in his story of bed capacity.

Bilateralism turns into a lengthy and dynamic procedure subject to the granted commitment of different clinic or department heads. Generating commitment for an issue by either talking individually to those involved or to their subordinates is takes time and requires the “detours” Hank mentions during the integration process. Pablo, the head of emergency care, agrees: “You must know that the shortest path between two points is not a straight line.” In a similar way, Robin denounces the possibility of “logical steps” but highlights the importance of developing a support network in the quote above. Bilateralism reminds Robin of playing chess: “With the clinics, it is like playing chess.”

Bilateralism provides an alternative for handling those issues that appear unresolvable within the executive board due to the mutual expectation of autonomy. Therefore, bilateralism serves as an enacted solution to the paradox of differentiation and integration. Bilateralism works on the premise that the different clinics and departments act relatively autonomously. Bilateralism allows pursuing issues that span the boundaries between the clinics by bilateral involvements of actors selected by the actor pursuing the issue. Nada, the nursing director, summarizes the underlying idea that relates bilateralism to garden thinking by elaborating on an image of neighbors (see section 4.2.1, p. 95): "Well, you steal your neighbor’s apples (laughs). No, no, it is also like this: you would also borrow the lawn-mower, and you would water the other's plants and trim his roses. Well, garden means: you need someone to take care when you are away. And that happens as well.” The notion of "neighbor" highlights the autonomy of different departments and the potential for cooperation on a one-to-one level.

Bilateralism leaves the poles of differentiation and integration intact; thus, it represents a both-and solution to the paradox (see Lewis, 2000; Clegg et al., 2002; Smith & Lewis, 2011). At the same time, and integral to bilateralism, handling the paradox involves accomplishing its latency within the executive board. The latency is accomplished by shifting conflictual issues to private conversations, to projects, or to let them dilute. In light of the paradox literature, bilateralism explicitly marks that the paradox is accepted within this organization as the underlying assumption of granting mutual autonomy due

to the differentiation of the clinical and departmental knowledge-intensive work. The data presented here as well as in chapter 4 shows that the organizational members are aware of the paradox of differentiation and integration. However, bilateralism does not lead to confronting the paradox. Such confrontation may occur in private conversation, but the interview respondents note this to be difficult (see Table 5-7, p. 136).

The reported excerpts of the board's discussion suggest that confrontation is avoided within the executive board. Therefore, bilateralism could be viewed as a defensive response to the paradox (Jarzabkowski et al., 2013; Lewis, 2000; Lewis & Smith, 2014; Smith & Lewis, 2011). But, bilateralism does not evoke a vicious circle as these studies suggest. Also, leaving issues unresolved and ambiguous did not become problematic neither to the hospital integration nor to the involved managers, as may be suggested (Abdallah et al., 2011).

Furthermore, bilateralism remains in place. Organizational members report their explicit understanding of it as a pattern "that is quite formative around here" (Nada). Therefore, I consider bilateralism as an informal routine of Laho. As a routine, it is a way to lead with the consent of the led (Denis et al., 2001). The analysis of bilateralism displayed in Table 5-6 shows that "bilateralism" provides a structure for who triggers and becomes involved in an issue, in how an issue is defined, how an issue receives attention and commitment, and when such issues occur. Bilateralism is a routine with the task of moving issues forward that span the boundaries of the different clinics and departments at Laho:

- *Who becomes involved* is up to the respective clinic or the department. Likewise, the CEO and non-medical departments approach others in a bilateral way, particularly on organization-wide issues prone to be controversial.

- *Topics (what)* mainly emerge from the respective actors. To enter the organizational agenda more broadly, the executive board or meetings of clinic heads serve as a first resonance for "*sounding*" an issue. Alternatively, topics are subsumed under existing projects or attention with clinics is raised with the subordinates of a clinic head first.

- *Reaching support and commitment (how)* occurs in private conversations bilaterally on a one-to-one basis before entering a formal setting like the executive

board. Addressing the diverse interests often takes a lengthy cascade of bilateral conversations and may require zigzagging towards the envisioned decision.

- *In terms of time (when),* issues are triggered situatively by those clinics, departments, or hospital management with the concern. The period of generating commitment varies as actors reach agreements with their counterparts. Thus, bilateralism impacts on the duration besides the urgency of the issue.

5.2.4 Paradox latency in the board and salience with its members

Bilateralism describes the relation between the poles of the paradox of differentiation and integration. It depicts the enacted solution that also accomplishes the latency of the paradox. This accomplishment occurs in the group setting of the executive board. At the same time, the paradox is salient to the individual members of the executive board. They are quite aware of the tension between differentiation and integration. This individual awareness is clear in bilateral conversations like research interviews but hardly in the group setting of the executive board. As part of bilateralism, refraining from openly addressing conflictual issues is limited by the "desire for harmony" (see excerpt 1, Table 5-1, p. 120). The following Table 5-7 provides further data on the difficulties of communicating openly within the executive board.

Interview Partner	Data /description	2nd order concept	Aggregate dimension
Torsten, head of anesthe-siology	There is a strong desire for harmony. Here at Laho, you try to avoid interfering with someone else's domain, and rather try to stay in harmony with one another. That is also part of the garden thinking	Avoiding conflict	Incommu-nicability of differences and conflicts
Hank, CEO Laho	The politicians praise us for the integration, because there was no public uprising, the doctors remained quiet and are satisfied now. The integration is widely accepted and I need this support to really do something	Success means a calm initiative	
Robin, head of Finances	It would be really – underlined three times- really helpful to genuinely engage in an open discursive struggle, and put the truth on the table within the executive board. But instead you have to watch out all the time, what you say.	Desire to openly communicate differences	
Pablo, head emergency doctor	Sometimes, I really would like to tell my colleague clinic heads: 'Come on. Let us put our cards on the table and tell each other what is really at stake.		
Nada, nursing director	I can be straight and emotional in my office. But if someone makes me angry it does not belong to anywhere outside this door.	Certain things do not belong to the outside	
John, head of Surgery	John explains his idea of structuring the executive board. Instead of clinic heads he suggests placing there one clinical director, and one of the administrative departments. Such a position would require handling the different interests and views of the colleagues of other clinics in the board: "If the head surgeon is	Shifting differences from the board to the subordinate	

Interview Partner	Data /description	2nd order concept	Aggregate dimension
	the clinical director, then it is impossible to just pursue his own interests. You would become your colleagues' enemy. Instead you would automatically look after your peer clinic heads. Otherwise there would be chaos and you would get mobbed in a way that you would not have a chance to survive."	level	
Sam, head of the palliative center	Observation: The leading oncologist and the head of the palliative care center continuously engage in heated discussions on whose patient it is		
Clinic Head Symposium (Observation)	During the workshop on sounding the topic of "process orientation" in Fall, 2005 with the heads of clinic, their discussion turns to the risk of fragmentation as a result of specialized medical disciplines. The discussion circled around what good patient treatment was about until Hans, the head of cardiology, asks the question: "What do we, as a hospital, as the group of clinics, mean by 'success'?" Nobody answers the question, until one clinic head suggests to move over to the next point of their agenda.	Remaining ambiguous by diluting the issue with silence	

Table 5-7: Incommunicability of differences

The data of Table 5-7 from members and non-members of the executive board point out the incommunicability of potential conflicts or differences. Robin, the head of finances, states: "It would be really – underlined three times – really helpful to genuinely engage in an open discursive struggle, and put the truth on the table within the executive board. But instead you have to watch out all the time, what you say in that setting." Instead, such issues are transferred to private conversations. Even there, it is not always possible to raise them openly. Pablo, the head of emergency care, states: "Sometimes, I really would like to tell my colleague clinic heads: 'Come on. Let us put our cards on the table and tell each other what is really at stake.'"

5.2.5 The duality of the paradox and the coordinating routine

The analysis shows that bilateralism is a routine that coordinates the actors who represent different clinics and departments and thus the different meaning structures. The difference of meaning structures manifests in the mutual expectation to grant autonomy to one another. As a result, the executive board does not appear to be the space that moves organization-wide issues forward directly. Alternatively, bilateralism compensates for this challenge of the executive board and handles the paradox of differentiation and integration in such a way that the paradox becomes latent. Organization-wide issues like the hospital integration or other similar issues move forward within this organization by means of handling conflictual issues in private conversations, shifting them into projects, or by diluting them as unresolved.

The paradox of differentiation and integration therefore requires bilateralism as a routine that leaves the poles intact (arrow 1 in the below Figure 5-2). At the same time, actors draw on the assumption of clinical and departmental autonomy to explain the coordinating routine of bilateralism (arrows 2 and 3). As both require one another, they form a duality where duality is defined as two components that are complementary albeit potentially contradictory (Farjoun, 2010). The paradox requires the routine, and the routine reproduces the paradox by handling it and rendering it latent (arrow 4). Like the paradox of differentiation and integration, the coordinating routine resonates with the meaning structures it relates through the assumption of mutually granted autonomy (arrows 2, 3, 5, 6). Bilateralism accomplishes the latency of the paradox through shifting arising tensions to private conversations, into projects, or by diluting them as unresolved. Bilateralism maintains ambiguity and leaves conflictual issues unresolved at the time of their salience (Abdallah et al., 2011; Smith, 2014). Figure 5-2 summarizes this description and displays the relationship between the foundational paradox and the coordinating routine that includes the paradox's latency.

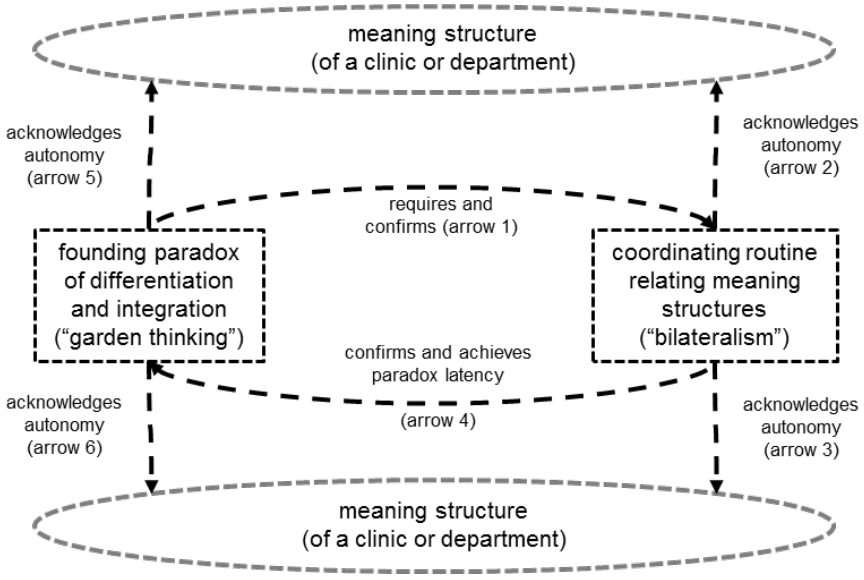


Figure 5-1: Paradox and coordinating routine in a pluralistic setting

The duality of the paradox and the coordinating routine illuminates on how this pluralistic organization achieves stability. The stability results from at least five reasons. First, accomplishing an organization-wide issue reaffirms that bilateralism works. Nada, the nursing director, summarizes: "But for the time being it works …. It works with some pains we can handle." Such pains occurred in the Adipositas initiative, for example, without jeopardizing the initiative (see excerpt 3, Table 5-3, p. 124). Also, the

hospital integration proved the benefits of bilateralism. Hank says: “the politicians praise us for the integration, because there was no public uprising, the doctors remained quiet and are satisfied now. The integration is widely accepted and I need this support to really do something.”

Second, bilateralism provides benefits by reassuring the clinical and departmental autonomy that allows their heads to push their own issues. Any change to bilateralism would require the consent of those who benefit from it (Denis et al., 2001). In turn, the granted autonomy rests on the assumption that specialization of expertise is essential for the hospital. Gabriel (head of infrastructure and organization) notes: “They [the clinic heads] have to develop their specialty so that they continue to be successful.”

Third, bilateralism is an uncodified informal routine but is well known within the studied hospital. Attempting to alter this routine would be difficult because of its informality, which makes a comprehensive description of its related aspects difficult.

Fourth, the very performance of bilateralism through private conversations is hard to assess for those not present in these encounters. Given bilateralism as an enacted routine, it would be hard if not impossible to interrupt its performance. As Gustav, the directors’ board president, mentions: “a lot of issues go through the informal networks of personal relations between the clinics.”

Fifth, bilateralism stays in place even when there is a call for explicit rules to coordinate clinics and departments with one another and with the executive board. Besides the benefits for the involved and its informality, there is the following catch: Developing more explicit rules would have to be developed within and through bilateralism. Doing so would be a contradiction in terms. Developing more explicit rules would imply enacting the informal private conversations to generate commitment in order to change this very routine. Attempting to change bilateralism by enacting it would demonstrate that bilateralism works while in fact questioning its proposed alternative.

For these reasons, I consider the duality of the paradox and its coordinating routine as a theoretical mechanism to explain the stability of a pluralistic organization. My findings provide an insight into how pluralistic organizations “hang together” (Kraatz & Block, 2008: 257) despite unsuccessful sensemaking (Ericson, 2001), divergent interests (Jarzabkowski & Fenton, 2006), escalating perpetuating conflicts (Bate, 2000),

escalating indecision (Denis et al., 2011), diluting change initiatives in various ways (Lozeau et al., 2002), resistance (Kellogg, 2011), difficulties to learn from failures (Edmondson et al., 2001), or undermining effects of previous decisions on current ones (Denis et al., 2001). The duality of the paradox and the coordinating routine creates stability and therefore offers an alternative way to view hospitals as change-resistant (Pettigrew, 2012). The duality serves as a bootstrap (Barnes, 1983) by which the studied organization pulls itself out of the mud that it re-creates through its founding paradox (Putnam, 1986). This continuous pulling is achieved with a coordinating routine like that of bilateralism. Bilateralism thereby adds to the insight of Denis et al. (2001) that the leaders require the consent of the led in that it shows how this is accomplished.

5.3 Discussion: The duality of coordinating routine and paradox

The analysis concluded by proposing a theoretical model that relates the paradox of differentiation and integration with a coordinating routine as a duality. The model helps to explain the stability of pluralistic organizations. Integral to this model is the latency of the paradox as an active accomplishment.

In comparison, the paradox literature assumes paradox latency and hardly explores how an organization achieves it. Rather, empirical studies and theoretical conceptualization are concerned with the salience of paradox and its handling. These works seldom turn to the enacted solution of a paradox and to the latency this solution achieves. This is why I explored the latency of paradox and the enacted paradox solution empirically.

These insights imply three contributions to the paradox lens. First, the coordinating routine of “bilateralism” handles the paradox of differentiation and integration in a both-and way. It serves to move organization-wide issues forward while leaving the different meaning structures intact. As a routine, it emerged from the situative practice and is enacted prior to managers’ attempts of deliberately handling the foundational paradox in a different way.

Second, the coordinating routine achieves the latency of the paradox. This invisibilization occurs on the interactional level of meetings through transferring conflictual issues to projects and bilateral conversations or through diluting the issue. At the same time, the paradox is salient to the individual members.

Third, the coordinating routine and the paradox form a duality. The mutual relationship helps to explain their persistence within the organization that is supported by the informality of the routine and its resonance with the different meaning structures by acknowledging the respective autonomy.

Extending *routine dynamics* to pluralistic organizations, this study contributes to the emerging interest of relating routines by identifying a coordinating routine that relates meaning structures and routines (D'Adderio et al., 2012; Parmigiani & Howard-Grenville, 2011). Furthermore, the empirical insights underscore the theoretical argument within routine dynamics of mutually held expectations as a condition for recognizing a routine. This insight specifies what a shared understanding means (Dionysiou & Tsoukas, 2013; Feldman & Rafaeli, 2002).

5.3.1 The coordinating routine as an enacted solution

The first contribution is that the coordinating routine of "bilateralism" handles "garden thinking", the paradox of differentiation and integration, in a both-and way. "Bilateralism" provides a way to move organization-wide issues (integration) forward while leaving the different meaning structures (differentiation) intact. As a routine, bilateralism emerged from the situative enactment prior to managers' attempts of deliberately handling the paradox. The routine draws on the mutual expectation that knowledge-intensive work associates with mutual autonomy.

In comparison, the paradox literature hardly explores the prior and situatively enacted solution to a paradox. Empirical studies rather focus on deliberately handling paradoxes once they have become salient and the conceptual models hardly incorporate the prior solution of the paradox under study (see section 2.2.2, p. 37ff.). As one exception, Jay (2013) incorporates the previous organizational understandings that impact on how the top management interprets ambiguous environmental cues. As another exception, Andriopoulos & Lewis (2009) mention the prior solution of handling the contradictory relationship of exploration and exploitation on the level of "personal drivers" (ibid., 705f.) in loose and tight coupling with customers and on the company's strategic intent to combine exploration and exploitation. The data reveals the contradiction between the poles but lacks detail on how the contradiction was handled within the organization. For instance, handling loose and tight customer relations is mentioned to involve "purposeful

improvisation" (ibid. 705), but without providing a detailed account of how it occurred. Likewise, a 'pragmatically idealist vision' (ibid: 703) is found to help combine both exploration and exploitation. In light of my findings, such a vision would be sufficiently broad and ambiguous to allow the actors to handle issues of tension in situ.

The relational view of paradoxes argues that the opposing poles of a paradox relate in a mutually constitutive way, which is enacted situatively and locally (Clegg et al., 2002). These authors elaborate on individual actors that relate structure and action through improvisation. Coordinating routines help to extend from the individual level because routines coordinate and relate different actors (Ockhuysen & Bechky, 2009) and different routines (Jarzabkowski et al., 2012).

Bilateralism exemplifies such a coordinating routine. It relates the opposing poles of differentiation and integration. This routine serves to move organization-wide issues forward. It expresses the emerged solution to the founding paradox that has hardly been considered in the paradox lens. My insight complements this literature by illuminating the solution to the paradox that is enacted prior to its salience.

Attending to the collectively enacted solution provides important insights for those who aim to design and to embed proposed solutions to paradoxes (see section 2.2.3, p. 42 ff.). Such a proposed solution differs from the enacted one. At the same time, the proposed solution enters the organization through the enacted solution. In my case, the proposal to change from bilateralism to rules implies that the issue should move forward bilaterally. This is the case because the enacted solution continues to relate the opposing poles situatively and locally (Clegg et al., 2002), while a proposal of its own change is made. Proposing a solution to a paradox is therefore self-contradictory. A proposed solution means to alter an enacted one, and attending to the latter helps to explain why embedding paradox solutions is a current open issue in the literature.

There are at least two more reasons for this challenge, which are the topic of the subsequent contributions: the active accomplishment of paradox latency and the mutually constitutive relationship between the paradox and the coordinating routine.

5.3.2 The coordinating routine achieves paradox latency

The second contribution is that the coordinating routine accomplishes paradox latency. This invisibilization occurs on the interactional level of meetings through transferring conflictual issues to projects and bilateral conversations or through diluting the issue. At the same time, the paradox is salient to the individual members.

For the paradox lens, paradox latency is central to the general assumption that paradoxes are integral to organizations. The literature identifies that the necessary conditions for paradox salience are plurality, change, and resource restriction (Smith & Lewis, 2011; Lewis & Smith, 2014). Prior to such circumstances, a paradox is said to "remain latent" (Lewis & Smith, 2014: 133), outside the attention (Clegg et al., 2002: 488), and dormant until an issue triggers its awakening (Pratt & Foreman, 2000: 20). The literature assumes latency but hardly explores what it means, to whom it applies, and how it is achieved. Paradox latency remains vague in recent theoretical models. These include latency mainly as their starting point (Andriopoulos & Lewis, 2009; Jarzabkowski et al., 2013; Jay, 2013; Luescher & Lewis, 2008; Smith & Lewis, 2011).

As exceptions, Clegg et al. (2002) and Abdallah et al. (2011) associate the handling of paradoxes with accomplishing latency. Building on these studies, attending to the performance of a coordinating routine helps to detect how paradox latency is achieved. Empirically, I identified the patterns of shifting conflictual issues to bilateral conversations, to projects combined with enlarging the scope of the issue, and to diluting the issue. These empirical insights illuminate how paradox latency is enacted situatively and locally within meetings, while the paradox remains salient to the individual members. Therefore, I conclude that paradox latency is an active accomplishment that is integral to the enacted solution of the coordinating routine that relates the poles of differentiation and integration.

These insights help to further advance the paradox lens in three ways. First, conceptually, showing paradox latency as an active accomplishment strengthens the central assumption that paradoxes are integral to organizations. So far, we assumed that paradoxes remain latent, but we did not describe how to accomplish this latency.

Second, accomplishing latency is more nuanced than the literature appears to imply. So far, some literature suggests that latency implies organizational members to be unaware

of paradoxes (Luescher & Lewis, 2008; O'Connor, 1995; Westenholz, 1993). My insights show that the organizational members may be aware of the paradox, and collectively enact its latency as part of their routinized handling the paradox.

Third, accomplishing latency being integral to the enacted paradox solution implies that paradox latency influences proposed solutions. Recent empirical studies and theoretical models tend to suggest that a paradox remains salient once organizational actors engage in handling it (Jarzabkowski et al., 2013; Jay, 2013; Lewis & Smith, 2014; Smith & Lewis, 2011). Responses to paradox and their dynamics hardly address this point explicitly and do not explore how salience is maintained or whether proposed solutions also contribute to paradox latency. Clegg et al. (2002: 488, emphasis added) note that "choosing and finding a balance between the two extremes of a paradox or replacing that tension with a synthesis helps managers to push important dynamics *out of the realm of attention*." Abdallah et al. (2011) contains a similar hint. These authors explore how managers use "quasi resolution to conflict" (ibid: 340) and "strategic ambiguity" (ibid: 342) "so that contradictions or paradoxes that were previously seen as intractable *appear to be dissolved* or overcome." (ibid: 335, emphasis added).

In summary, I suggest to consider paradox latency as an active accomplishment that is performed collectively even if the paradox is salient to individual members. If paradoxes are integral to organizations, then paradox latency is as well. The organization is "driven by the continuous need to handle this paradox and thus tends to oscillate between visibilizing and invisibilizing [it]" (Schoenenborn, 2011: 674). Thus, paradox latency is not only a starting point of theoretical models. But also paradox latency is integral to the enacted solution of a paradox and therefore critical for proposed solutions to a paradox.

5.3.3 The duality of the paradox and the coordinating routine

The third contribution is that the coordinating routine and the paradox form a duality. This mutually constitutive relationship helps to explain their persistence. The persistence is further supported by the informality of the routine and the resonance with the different meaning structures. At a minimal level, the paradox and its enacted routine solution provide core components to understand a pluralistic organization as a paradoxical one.

The paradox literature argues that there is a duality between the poles of a paradox. As a paradox emerges from self-reference (von Foerster, 1994), it denotes "contradictory yet *interrelated* elements [poles] that exist simultaneously and persist over time." (Smith & Lewis, 2011: 382, emphasis added). We know from the literature that each pole can only exist because of the other one (Clegg et al., 2002; Poole & van de Ven, 1989; Putnam, 1986). Accordingly, many identified so-called "both-and" approaches follow the idea of mutual constitution when researchers highlight practices of differentiation and integration (Andriopoulos & Lewis, 2009) or consistently inconsistent decision-making (Smith, 2014) as temporal or so-called workable solutions (Luescher & Lewis, 2008).

As a meta-theoretical framework (Lewis & Smith, 2014: 134, emphasis added), the paradox lens argues that "paradoxical tensions reflect polarities that are interrelated aspects of a *greater whole*". Lewis (2000: 762f) displays the greater whole with the Yin and Yang metaphor. She suggests that the polarities "obscure the interrelatedness of contradictions" (ibid: 762). Thus, shifting to one pole of the paradox will eventually lead to a reverse development to the other pole (ibid: 763). In correspondence with empirical studies, the greater whole indicates the paradox, although many studies emphasize the tension and less the complementarity of the different poles (see section 2.2.1, p. 32). There are few works that specify the relationship between the poles (Clegg et al., 2002).

Routine dynamics helps to depict this relationship. Routines relate actors and other routines through mutually held expectations (Dionysiou & Tsoukas, 2013; Feldman & Rafaeli, 2002; Jarzabkowski et al., 2012; Zbaracki & Bergen, 2010). Therefore, routines provide a means to grasp the relationship between the paradox poles.

The routine of bilateralism reveals the patterned relationship between the poles of the paradox of differentiation and integration in the studied organization. The routine itself is enacted locally. It emerged from the ways of acting without a deliberate design (Clegg et al., 2002: 488). This coordinating routine is associated with the different meaning structures and handles the challenge of the different meaning structures, i.e. the paradox of differentiation and integration. At the same time, the coordinating routine refers to the paradox and therefore provides the reason for its persistence. I therefore suggest that the paradox and the coordinating routine form a duality.

The proposed duality of the paradox and the coordinating routine furthers illuminates on depicting a pluralistic organization as paradoxical. In chapter 4, I suggest that a pluralistic organization like the studied hospital is based on the paradox of differentiation and integration. Because the paradox literature gives priority to the tensions between the sub-systems, the literature tends to underscore the importance of the sub-systems' complementarity. As a result, the accomplishment of stability of a pluralistic organization has not yet been sufficiently researched (Kraatz & Block, 2008). The identified coordinating routine of bilateralism helps to address this open issue. Bilateralism exemplifies a means to move organization-wide issues forward and draws on the expectation of the different sub-systems to acknowledge autonomy. Since the identified coordinating routine relates with the paradox in a mutually constitutive way, this duality provides a mechanism to theorize a pluralistic organization as paradoxical. This theorization includes the known characteristics of knowledge-intensive work processes, ambiguous power relations, diverse strategic interests and different worldviews (Glouberman & Mintzberg, 2001a; Jay, 2013). The duality of the paradox and the coordinating routine moves beyond these characteristics. The duality illuminates on how a pluralistic organization achieves stability in light of its improbability.

The use of the duality of a paradox and a coordinating routine to depict a pluralistic organization implies the following for the paradox literature. First, the duality strengthens the paradox lens. Paradoxes are not only integral to organizations, but a pluralistic organization can also be viewed as an expression of the paradox and its handling. With the duality, we gain a view of an organization as paradoxical (Luhmann, 2000; Schoenenborn, 2011). In comparison, the literature tends to view paradoxes to unfold within in the context of an organization.

Second, the duality implies reconsideration of the role of leaders and managers. Among others (Ford & Backoff, 1988; Luescher & Lewis, 2008; Smith, 2014), Lewis & Smith (2014: 131) argue to place "substantial responsibility on senior leaders to enable the interplay between differentiated efforts and see more holistic synergies…" Considering the organization as paradoxical, these senior leaders already act within the duality of a paradox and its enacted solution. Without considering this prior solution, we miss that their efforts respond to the enacted solution. This is why leaders' attempts of handling paradoxes may undermine their very aim: "action aimed at resolving issues creates new dilemmas that seem to undermine this resolution" (Abdallah et al., 2011: 334).

Third, viewing the organization as paradoxical shifts our attention towards stability and invites researchers to explore how stability is accomplished besides engaging with deliberate attempts to change (Denis et al., 2001). This path corresponds first to pluralistic organizations. They problematize stability by definition and therefore call for exploring how they can avoid disintegration (Kraatz & Block, 2008). Second, this path expresses a processual perspective that emphasizes organizations as temporal social orders that emerge from fleeting events as active accomplishments (Hernes, 2008). Furthermore, my study shares the dynamic view that Jarzabkowski et al. (2013) and Andriopoulos & Lewis (2009) call for and address. These authors show the dynamic relation between paradoxes. They relate paradoxes found on the individual, the group, and the organizational level in a mutually reinforcing way. Complementarily, my findings and insights reside with one paradox and its enacted solution. The duality they form emphasizes how stability is accomplished. In addition, my study complements Jay (2013) who shows how the top management team works through paradoxes by re-inventing their organizational understanding. My study shows the other side of this coin by demonstrating patterns of how to avoid such a process.

In conclusion, an organization would not exist without a situatively and locally enacted solution to the foundational paradox. The empirical investigation elaborates on this situative performance of the solution to the paradox within the top management team attuned to the accomplishment of paradox latency.

5.3.4 Routine dynamics extended to coordinating meaning structures

Routine dynamics helps to further advance the process perspective within the paradox lens. In this chapter, routine dynamics guided the explication of the coordinating routine that handles the founding paradox with both components forming a duality. This insight holds two contributions to routine dynamics.

First, the identified coordinating routine served to relate different meaning structures. We know that routines relate different actors (Dionysiou & Tsoukas, 2013; Feldman & Rafaeli, 2002; Zbaracki & Bergen, 2010) and that coordinating mechanisms relate routines as they emerge in their enactment (Jarzabkowski et al., 2012); they also relate with the organizational understanding (Rerup & Feldman, 2011). The coordinating routine of bilateralism illuminates empirically on how different meaning structures

relate. Therefore, my study helps to expand routine dynamics from the relating of different actors across routines towards different sub-systems of an organization. The study contributes to the increasing interest in routine dynamics by exploring the relation between routines (D'Adderio et al., 2012; Parmigiani & Howard-Grenville, 2011).

Second, regarding the coordinating aspect of routines, the literature debates what "shared" understanding implies. A routine requires that it be recognized as such (Feldman & Pentland, 2003). But, its understandings are multiple with different participating actors so that a routine is said to be a pattern in variety (Cohen, 2007). Thus, routine dynamics triggers the question of what it is that gives rise to recognize a routine when the different actors associate with different understandings. Rather than equal content (Feldman & Rafaeli, 2002), Dionysiou & Tsoukas (2013) argue that actors hold compatible expectations as a minimal condition. My empirical result strengthens this theoretical argument in that I did not find that the coordinating routine draws on a shared and equal understanding of the hospital. The coordinating routine rather draws on and enacts the mutually held assumption of granting autonomy by not interfering with another clinic or department. In this respect, my findings are associated with the insight of restoring a truce between the differences in expectations (Zbaracki & Bergen, 2010). These authors found that senior leaders restore the truce. In my case, enacting truce was a collective achievement that is integral to the coordinating routine of bilateralism.

5.4 Summary and the open issue of embedding paradox solutions

This chapter concerned my interest in the stability of a pluralistic organization. I build on the paradox literature that emphasizes a dynamic, processual, and relational view of the mutually constituting poles. These works broaden the common focus on the tensions between the poles to include their complementarity. Furthermore, the relation between the poles emerges generically in situative and local action without a deliberate managerial design.

Routine dynamics helps to elaborate on the relation between the poles. Routines coordinate different actors and routines with organizational understandings. As enacted coordination, routine dynamics complements the paradox literature that focuses on handling paradoxes once they have become salient. Routine as coordination attends to the enacted solution when the paradox is assumed to remain latent. Although paradox

latency is a core component to the paradox lens, it remains vague in what it means, where it occurs, and how it is achieved. Thus, I pursue the research question: How does a pluralistic organization handle a paradox and accomplish its latency?

The empirical results show a coordinating routine. It handles the paradox of differentiation and integration while accomplishing paradox latency within the executive board despite the paradox's salience to its individual members. The coordinating routine of "bilateralism" is a means of moving an organization-wide issue forward without interfering with the clinics' and departments' autonomy. My analysis shows that bilateralism is a routine that handles the paradox of differentiation and integration. This routine draws on the paradox and reproduces it at the same time. Both form a duality.

These insights offer three contributions to the paradox lens. First, the coordinating routine provides a both-and way of handling the paradox. It relates the poles of differentiation and integration and emerges not as a deliberately designed solution but as one that is enacted situatively and locally. Second, the coordinating routine accomplishes latency by transferring conflictual issues into a project, to a bilateral conversation, or by diluting the conflictual issue. Paradox latency is not only a conceptual assumption but a collective accomplishment even if and when the paradox is salient to the individual members. Furthermore, paradox latency gains importance in deliberate attempts of handling paradoxes because it shields the enacted solution from deliberate change attempts. Third, the duality of the coordinating routine and the paradox suggests considering a pluralistic organization as paradoxical. I thereby offer a specification of the pervasive Yin and Yang metaphor that considers the poles of a paradox as forming a greater whole. This greater whole is the organization composed (at least) of the paradox and the coordinating routine. By building on a processual view within the paradox lens, this chapter expands from viewing paradoxes as active accomplishments (chapter 4) to viewing their enacted solution and paradox latency as collectively accomplished.

My insights also offer two inspirations for routine dynamics. The coordinating routine relates different meaning structures and thereby groups of routines, extending routines as a means to coordinate actors, and different routines in their association with organizational understandings. Furthermore, my study contributes to the discussion on the shared understanding to recognize a routine given that they are patterns in variety.

The findings suggest that a mutually held expectation like mutual autonomy provides a minimal condition from which a routine may draw.

In this chapter, the research helps to depict that a pluralistic organization like the studied hospital accomplishes stability through the duality of the paradox and the coordinating routine. This chapter thereby provides an explanation of why a pluralistic organization appears impermeable to deliberate change attempts and why the organizational members struggle with embedding alternative solutions to a paradox. Investigating how paradox solutions can be embedded within an organization is the topic of the next chapter.

6 Venturing change: Routinizing reflection

"We know that reflection paralyzes action, but that an unreflected action sooner or later leads to a disaster, so that we need to oscillate between the two..."
(Barbara Czarniawska, 2008:129)

The third research interest encompasses the process of deliberately changing a pluralistic organization. This is a daunting task for practitioners, particularly in view of the previous chapters. First, a pluralistic organization like a hospital is founded on the paradox of differentiation and integration (Chapter 4). Differentiation calls for integration while impeding it. Second, the paradox is unfolded by a coordinating routine that stabilizes the relationship between the differentiated sub-systems and achieves paradox latency (Chapter 5). Thus, deliberately changing a pluralistic organization is challenging.

The paradox literature tells us that paradoxes become salient in situations of deliberate change because the differences between meaning structures surface and often turn into opposition. Handling these opposites requires reflection by individuals (Lewis, 2000; Smith, 2014) and groups (Jay, 2013; Luescher & Lewis, 2008) to envision alternative solutions to the paradox. The paradox literature currently raises the question of how to embed these solutions within an organization (see section 2.2.3, p. 42ff.). I address this open issue with the following research question: How can paradox solutions become embedded in a pluralistic organization?

The point of departure is reflection, which is central to the paradox literature and invites routine dynamics. Routine dynamics expands reflection from the designers of a paradox solution to those on the receiving end. The focus of the following results lies in how reflection is routinized both as a medium and an outcome of a deliberate change process.

This chapter is structured as follows. First, the results on the deliberate change of the nursing unit during the hospital integration are presented in two parts. The first part depicts what organizational members call “family nursing”. It is the meaning structure of Reho’s nursing unit before the change initiative. I compare this meaning structure with the one of chapter 4 (see section 4.1.3, p. 88ff.) that represents a so-called “professional nursing” to which “family nursing” was supposed to adapt.

The second part of the results elaborates on how this change took place, and it is subdivided into three episodes. These three episodes start with a failed attempt, which involved outside feedback. The following two episodes highlight the emergence of reflective routines and the movement towards the proposed "professional nursing". Each episode contains the event history, the description of selected reflective routines, and the observed impact on the nursing unit. Second, and based on these insights, the analysis concerns reflective routines as an outcome and a medium of the change initiative. The analysis results in the process model of establishing reflective routines to handle the salient paradox of opposing meaning structures. Third, I discuss this conceptualization with the paradox literature and argue four contributions. Establishing reflective routines shows the process of how reflection on the change initiative becomes integral to the organization. Establishing reflective routines relates the opposing meaning structures. Establishing reflective routines collapses the distinction between those designing and those implementing paradox solutions. Furthermore, establishing reflective routines indicates that designing and implementing occur simultaneously rather than sequentially. These insights address the current open issue of the paradox lens. They also speak to routine dynamics that began to explore the deliberate change of routines.

6.1 Results on "family" and "professional" nursing

My empirical case of deliberately creating and changing care and professional routines involved a shift from what practitioners called a "family" towards a "professional" understanding of nursing. In the following section, I describe the family understanding and compare it to the professional one of section 4.1.3 (p. 88ff.). The description and the comparison occur alongside a selection of caring, organizing, and reflecting routines.

6.1.1 "Family" nursing at Reho

Particularly during the beginning of the change initiative, the nurses viewed their department as a *family*. The family understanding points in two directions: the way to care for patients, and the relation between the organizational unit and the nursing employees. First, caring within the family understanding means that sick people should "feel good around here". Nurses use phrases like "cozy", "snugged in here", and

"family" to describe the atmosphere. According to the nurses, the "family" atmosphere is what the patients favor. It is illustrated in the following observation:

"On a busy day in late November, I rush after a senior nurse along the hallway who gathers blood samples of various patients, checks medications, and tries to reach a colleague on the phone to help out the next day, while others distribute dinner to the patients of the ward. Stopping short in front of one patient room, she slows down, quietly opens the door and we enter the darkening room. The nurse greets the middle-aged lady in her pajamas by name in a low voice. She sits down gently besides her on the bed, the dinner tray in front, and begins feeding her slowly small portions of mashed potatoes and vegetables. No word is spoken, and after a while the lady puts her bald head on the nurse's shoulder and sighs. I feel like an intruder and leave the room. After her return, the nurse explains that the lady is in the ultimate stage of cancer. She died a week later."

Second, the relation of nurses and their unit expresses the family understanding in two ways. Relations among nurses and between the different wards are rather informal so that people find the time to chat with each other and visit friends of other wards for coffee during the day. Also, work shifts are structured towards work-family compatibility in what is called a "portioned" shift. A portioned shift means that a nurse works in the mornings and early afternoons with a three hour break at midday; this break is particularly convenient to go home and take care of the children during their lunch break at school. Likewise, the afternoon shift is portioned. A nurse works on midday for three hours, and returns to work after her morning colleague has left in the afternoon. At night, a reduced staff performs the so-called "night watch" to monitor patients.

In *relation to medical doctors*, the family understanding emphasizes close cooperation and subordinate support. One needs to be "friendly with the clinics" (Ulrika, HN-3). Close cooperation is necessary says Hector, Reho's nursing director: "you have to cooperate closely. If not, everything goes down the drain". During the daily work on the wards, such close cooperation means that medical doctors do not only give instructions to nurses with regards to patient treatment as is common in all hospitals. But, medical doctors also instruct the wards on organizational topics (e.g., on the times for the ward rounds, on admitting additional patients). Overall, following a long tradition, nursing as family is a support function to the medicines. Nurses "… have always been the helping hand, those who serve the medical doctors…" (Herbert, a nurse from Laho).

Caring routines follow a so-called "functional care concept". The nurses focus on particular tasks such as checking the vitals of patients (pulse, blood pressure, and pupil reaction to light changes), taking blood samples or body secretions for analysis, and treating wounds besides supporting their daily hygiene activities including eating or supporting patients by taking time for conversations. Jill, a nurse, explains the downsides of the functional nurse concept. First, numerous handovers from the outgoing to the incoming nurses cause the risk of losing information. Second, the patients are sometimes unsure who is responsible for them. They encounter many professionals during the day, which may be confusing. Third, when nurses cannot directly respond to patient questions but need to ask back her colleagues, "patients gather the feeling we are incompetent".

Within the family understanding, caring for patients or caring routines take priority over *organizing* work, such as documenting nurse activities consistently or the monthly planning of the shifts (man power planning). Nurses call this work "administrative"; this phrase is of devalued meaning in comparison to caring work because they do not consider it "real" work (Henrika, HN-1). As a consequence, I observed that documenting or manpower planning was performed regularly after the nurse's end of shift in overtime. Head nurses reported that they often planned the shifts at home. Such manpower planning is referred to as the "wish plan" and is oriented towards the preferences of the nurses when they need free-time because of family issues (e.g., summer vacation). This perception about executing administrative routines seems to be reinforced by the ward team as Henrika (HN-1), a head nurse, explains: "When I work with the computer, my team does not consider that work … they think that I am not really working". Likewise, documenting nurse activities consistently and timely in order to generate internal billing to clinics and to provide information on the nursing unit's work capacity and performance is rather perceived as an unwelcome distraction from patient care. Vivian, a nurse developer in charge for systematically adapting care standards, notes: "They do not see much sense in such things as documenting their care activities." Accordingly, nurses often perform documenting care activities at the end of their shift, and hence, they are not always comprehensive and consistent. Likewise, a nurse, Joan, complains: "I have the feeling: I do something, and I need to document it, again and again. The documenting takes more time than the doing." Jill, another nurse, reacts similarly when she coordinates work shifts: "I hate this telephone and organizing all the shifts".

Reflecting routines of the family understanding are rather informal. I observed reflecting on particular care situations, for example, regularly during the ward's morning coffee break when nurses sit down to have breakfast or in private conversations among nurses. The nurses also discuss other topics of the nursing unit or the wards during the morning coffee break, during lunch, or when visiting colleagues to have a coffee. "Sitting together and chatting a bit" is important for the team spirit, a nurse describes. But the nurse also acknowledges that it involves considerable gossiping about other colleagues, the medical doctors, the nursing unit, and the hospital. In more general terms, Jill perceives that there is too little feedback during the day when performing caring routines. "We work with one another with the attitude that you are a good professional and I am good professional, and that makes it difficult to give feedback when you see something happening." Thus, reflection on their work appears rather rare, ad hoc, and mostly in private conversations. On the one hand, there is a demand for increased reflection in times of high workload or having a "time out", as Henrika (HN-1) calls it. On the other hand, nurses refrain from asking questions in such times to not be seen as "just standing around and asking questions all day" (Elaine, HN-2).

6.1.2 Comparing family and professional nursing as meaning structures

The "family" meaning structure was prominent in Reho's nursing, but the initiative to deliberately create and change routines was associated with the "professional" meaning structure (see section 4.1.3, pp. 88ff.). Each meaning structure depicts the background the nurses draw on when interpreting what is happening around them. Within the family meaning structure, the core of caring for a sick person has priority, whereas the professional meaning structure aims to deliver a professional service. These different understandings manifest in the particular caring, organizing, and reflecting routines. Routines like documenting or manpower planning differ between the two. Within the family understanding, these routines have little priority. Within the professional understanding, they are pre-requisites for professional caring and for running the nurse unit. In addition, reflective routines are means to continuously improve caring routines. They are rather informal in the family meaning structure and are based on a mutual assumption of conducting good care. Caring routines within the family meaning structure appear to express a more traditional approach of focusing on the respective tasks and are accompanied by a family friendly work environment. Within professional

nursing, the aim is to practice primary care in which a nurse is responsible for designated patients and organizes nurse activities drawing on her own and her colleague's expertise. Both meaning structures treat caring routines and care concepts as primary in that organizing and reflecting routines result from how caring is understood and practiced. In other words, the knowledge-intensive work that lies at the core of the organization provides the background as to how organizational members understand their unit and do their work as professionals within it.

Table 6-1 provides a summary of both meaning structures.

Meaning Structure	Family meaning structure	Professional meaning structure
Under-standing	Caring means to provide a comforting, family-like atmosphere for a sick person, emphasizing to accompany the patient during his hospital stay. Nurses support medical doctors who give instructions on medical, nursing, and organizing topics.	Caring means to provide a professional service for the patient who knows his single nurse contact person. The nurse is the case manager of this patient, and is stays up to date with the development in the medicines and nursing science. Nurses are partners of medical doctors. Medical doctors instruct nurses on medical treatment issues.
Caring routine	Functional care with task-related expertise, structured in portioned shifts with many handovers, and numerous contact persons for a patient.	Primary care designates nurses to specific patients for whom they assume responsibility, coordinates with the patient the therapy activities, and ensures their enactment. Primary care is structured in a three-shift work day, thus decreasing the handovers.
Organizing routine	Organizing routines ("administrative work") are subordinate to caring routines, and often considered as distraction of patient care: ▪ *Documenting* care activities is something one has to do, but is often done late and inconsistent ▪ *Man power planning*: a wish plan oriented mainly towards the preferences of the employees Organizing routines are performed often at the shift's end or in over time.	Organizing routines are pre-requisites to ensure the functioning of the ward and the nursing unit: ▪ *Documenting* care activities occurs shortly after their happening throughout the day to be comprehensive and consistent ▪ *Man-power planning*: a duty roster oriented towards the necessities of the work load on the ward and nursing unit level. ▪ *Monthly report*: an artifact for budgeting, man-power planning, calibrating work-load between wards.
Reflecting routine	Reflecting is based on the assumption of mutually considering each other as good nurses, thus sporadic, ad hoc, and often informal in private conversations and during the morning coffee break.	Reflection is oriented to maintain the state of the art in medicines and nursing, focused on caring routines taken place regularly as: ▪ "Difficult case" discussions ▪ Projects to enhance nursing standards ▪ A nurse expert accompanying nurses in their work with patients.

Table 6-1: The family and the professional meaning structure

6.2 Results of establishing reflective routines in the nursing unit

Shifting from the family to the professional meaning structure provides an important background to the dynamic process of integrating Reho's nursing department into that of Laho. Rachel says: "After all it is a change in their self-understanding as nurses".

Furthermore, Vivian, a nurse developer deployed to Reho, points out the interconnectedness of caring and organizing routines: “There are so many things going on, and they are inter-connected. Like changing towards a 3-shift work day is closely related to the standards of nursing anamnesis and the handover procedure.”

The following section presents the deliberate change process in three episodes. The first episode starts with the trigger of the integration until the paradoxical tensions between the two meaning structures surfaces. The second episode reports on the entrance of Rachel, deployed from Laho, to accompany the Reho nurses in the process of adapting their routines. With Rachel becoming the nurse director at Reho, the third episode concerns the changes within Reho’s nursing department. After a description of the occurring events, the focus in each episode is on how reflection on the change initiative takes place as well as its observed impact on Reho’s nursing department.

6.2.1 Episode 1: Paradox salience in Reho’s nursing department

Episode 1 contains the narrative of the events that led to an open conflict between the involved actors of Reho and Laho. The conflict exemplifies the opposition between the family and professional understanding and the salience of their paradoxical relationship at the time. Second, the episode displays that the Laho members practice reflection in terms of feedback they provide to Reho’s nurses. Third, these feedback activities do not turn into reflection. One reason is that the content of the feedback and the way how Laho’s nurses conduct these settings do not associate with the family meaning structure, but rather with the professional one.

6.2.1.1 Event history episode 1

Episode 1 begins with the trigger of the change initiative at Reho in May 2003 and ends in June 2004. Figure 6-1 provides an overview on the events followed by a description.

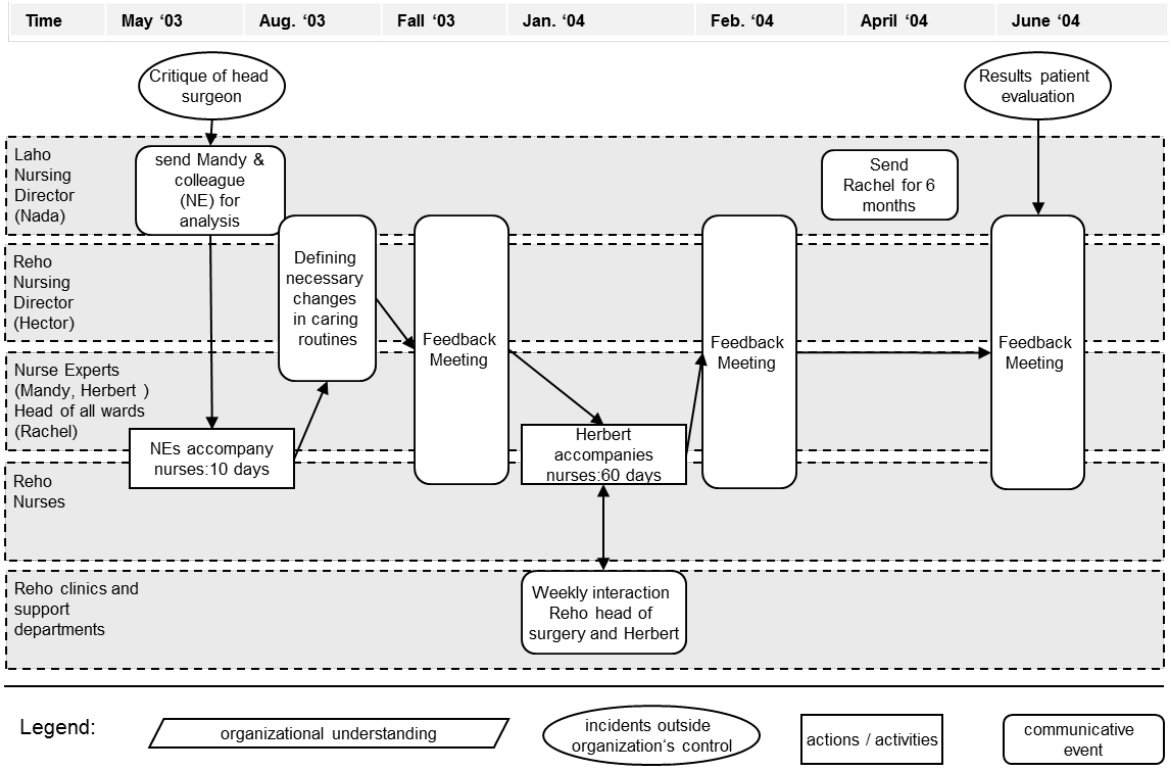


Figure 6-1: Integrating nursing, episode 1

In May 2003, John, the head of surgery, complains about inadequate professional standards. Nada remembers: "John said to me: you lost control at Reho. You have to do something about it." The nurses of Reho observe the proposed changes to become excessive: "At the beginning, the surgeons acknowledged that they would leave us our own way of doing things. But over time, their demands become more and more. We felt like being eaten alive", says Cheryl (HN-4).

In response to John's critique, Nada sends two nurses from the surgical department of the Laho to visit their colleagues at Reho for ten days. Mandy and her partner participate in daily work and feel "heartily welcome, even though we were the outsiders" (Mandy). Being present in the daily work on the wards, Mandy notes that "they were happy we came." During their visit, Mandy and her colleague concentrate on the caring routines, such as patient mobilization or wound treatment. They also assess the handling of patient data in the patient file, the ordering of material, and the managing of bed capacity. Analyzing these procedures, Mandy asks herself "what are the deficits here?" in comparison to the professional nursing practiced at Laho. Identifying deficits in terms of the content of standard caring procedures and in terms of how nurses use checklists and formal guidelines is their main focus. With regards to organizational tasks, they could only place recommendations: "When we saw something, which nurse leadership should

do, like ward guidelines, documentation, information flows. There, we could only recommend something. We could not instruct like: 'From now on, you do it like this.'"

In August 2003, Mandy and her partner report their analysis to Nada and Hector, the nursing director of Reho. According to Nada, the goal is "that Reho practices the same nursing as we do at Laho". The report entitled "measure catalog" contains a list of required changes in nursing standards. For example, the wound treatment and the pain treatment are to be "removed" and "replaced" with the ones practiced at Laho. Topics of organizing like changing the schedule of ward rounds are to be "discussed", and missing pieces of equipment are to be purchased. Hector takes notice of the results as recommendations: "The suggestions were helpful for me to see what we could use for our development."

In the fall of 2003, Nada, Mandy, and her colleague provide a "feedback" to the Reho nurses who they summon in the local meeting room on the fourth floor and remotely from the wards. "There we told them of all the caring topics. We told them honestly about everything that did not work and where they had deficits", says Mandy. According to her, the reaction of the Reho nurses was two-fold: some Reho nurses thanked them, while others were startled by the magnitude of deficits in nursing standards.

In January 2004, Nada sends a nurse, Herbert, for two months to Reho to support the implementation of the new or changed nursing standards. Herbert understands his task as to implement the Laho "folder of nursing guidelines", the exemplary file (see section 4.1.3, p. 89), at Reho. He engages with the Reho nurses in the daily work on the wards, and the Reho nurses appreciate his support. Ulrika (HN-3) says: "He came for quite some time, really trying to help us out and he did a lot of teaching on the job." Besides working on the wards, Herbert meets weekly with Anton, the leading surgeon at Reho, to "discuss how it is going, how to handle specific problems and such things" (Anton). Between the two, they decide on how to proceed to implement the guideline folder.

At the end of this period, Nada, Herbert, and Mandy summon the Reho nurses again for a feedback in the meeting room. They use an Excel spreadsheet with an overhead projector to state the issues that remained to be changed. The Reho nurses feel intimidated and angry: "It was almost like they were threatening us: 'you must change this and that, and if you don't, then…' It was like all we had done so far was not worth anything. All of us were furious" (Elaine, HN-2). Likewise, their Laho colleagues

become angry. Later on, Nada reflects: “It was difficult to change particularly those aspects in which the Reho nurses think they do them well. This was really challenging. But thank God, we then received the results of the external evaluation. Then it was clear. It proved that Reho’s nursing really lags behind.” The results of this patient satisfaction survey draws on data from the previous fall. According to Henrika (HN-1), the survey shows that the patients do not consider the Reho nurses to be very competent or caring. Nada presents these results to the Reho nurses in a third feedback meeting in June 2004. The Reho nurses are shocked and confused by this critique.

6.2.1.2 Reflective routines and feedback action side-by-side

During this episode, reflection on the change process occurred within the routines of the family meaning structure practiced at Reho and with Laho employees who discussed the change initiative internally and conducted feedback meetings with the Reho nurses. Table 6-2 contains a summary of these activities:

reflective routine	Who	What	When	How
Going for a coffee and chatting	• nurses of same or different wards	• personal impressions of the wards, the department, the hospital, other departments • encounters with patients, family members • caring routines	• ad hoc; idiosyncratic	• bilateral informal conversation
Z’Nüni (daily morning coffee break of wards)	• nurses of a ward		• daily in ward office room	• informal group conversation
Accompanying in performing caring routines	• Herbert, Mandy (Laho) • ward nurses (Reho)	• performing caring routines • in part organizing routines • structure of ward rounds	• temporary period (10 days, 2 months)	• reflection on action • training on the job
Feedback meetings	• Nada (Laho) • Mandy, Herbert (Laho) • head nurses (Reho) • ward nurses (Reho) • Hector (Reho)	• caring routines: deficits and required changes • equipment • qualification • organizing routines	• scheduled meetings	• structured according to the project plan of Laho
Herbert meeting Reho’s leading surgeon	• Herbert (Laho) • Anton (Laho)	• the current development, devising further steps	• once, twice a week during January-February, 04	• informal conversation

Table 6-2: Reflective activities and routines during episode 1

Within Reho’s family understanding, reflective routines are informal. They highlight the personal relationship between those involved. As Elaine (HN-2) explains, one goes for a coffee with a befriended colleague “to talk a bit about everything”. Such encounters occur situationally depending on the ward’s workload and among nurses with personal

relationships. On a more regular basis, the nurses on the ward engage in conversations regarding patients, the hospital, medical doctors, and all sorts of topics during lunch breaks as well as during their breakfast break at 9 am in the back of the ward's office room. Participating in this fixed break during which even medical doctors hardly interrupt, I observe informal group conversations among the nurses discussing whatever is currently important to them. The breakfast break appears a private context to converse openly among the ward team members.

In comparison to the informal settings of reflection at Reho, the Laho nurses held three types of feedback. First, for ten days or two months, respectively, Mandy and Herbert accompanied Reho nurses in their daily work. While accompanying the ward nurses, the Laho nurses felt welcome by their Reho colleagues with their direct support. Herbert recalls during the interview: "I tried to be available for them and their questions and I conducted training sessions for them." Daily engagement allowed them to work on "a lot of topics", says Herbert. "We worked on how to do the actual patient care work, but also in more organizational stuff, like the logistics of the material the nurses need for their work, the flexible ward rounds of the different clinics, and we also looked at the handovers at the end of a shift; a lot of topics." As noted above, his presence is appreciated at Reho: "He came for quite some time; really trying to help us out and he did a lot of teaching on the job" (Cheryl, HN-4).

Second, Herbert and Reho's head of surgery, Anton, met regularly to discuss what was going on at Reho's nursing on the surgical ward. Anton states: "I met with Herbert every week once or twice. We discussed how it is going, what are the challenges and problems and how to resolve them. So we could see how it develops and how we get the nurses up to our standard." This reflection on the change at Reho's nursing remained internal to these members of Laho.

Third, Reho nurses participated in three "feedback meetings" between the fall of 2003 and June 2004. Nada, Herbert, and Mandy summoned the Reho nurses and their nursing director, Hector, to the feedback meetings that took place in a meeting room that was separate from the wards. Mandy recalls: "And then we gave them at Reho a feedback. We mentioned all the caring standards we had analyzed. And we frankly told them what did not work and in which areas there were deficits." The feedback was in line with Nada's task of adapting Reho's nursing to that of Laho. The nurse experts presented their

view of Reho's family nursing from their perspective of professional nursing. The Reho nurses received these observations according to their understanding of family nursing. Henrika (HN-1) recalls: "It was like all we had done so far was not worth anything. All of us were furious." In particular, the Reho nurses find the feedback meeting in February 2004 dramatic: "This meeting was dramatic. All the wards were present, and Nada—I saw her for the first time really—and Mandy and Herbert. They held their presentation and there they just stated that this and that is to be improved here at Reho. This and that is not good. They put a slide on the projector, I find this terrible. And when we asked, if there was anything positive about our work or if all is bad, they got quite angry" (Elaine, HN-2). Her superior, Hector, agrees: "We do not need someone who comes here, summons everybody into a meeting room and tells us that we fail in all our work."

6.2.1.3 Observed impact: The salience of the paradox

At the end of this episode, the observable impact is the conflict between the members of Laho and of Reho. This conflict expresses the salient paradox in which the professional and the family meaning structure oppose each other.

The reflective activities offer three reasons for the conflict to occur. First, Reho nurses both disagree with the content and the conduct of the feedback provided, as Elaine (HN-2) indicates with her interpretation of using a projector. The deficit-orientation with its implication of a future professional understanding contrasts the family meaning structure at Reho. Each side observed the other in terms of its own understanding. The professional and family understanding turned into opposition.

Second, confusion adds to this opposition. The confusion arises from the perceived difference in accompanying Reho nurses and the feedback meetings. Henrika (HN-1): "We knew Herbert came to help us out here for the two months to improve our work. But in these meetings it turned into something quite different." On the one hand, Mandy's and Herbert's engagement with the Reho nurses in their daily nurse activities is appreciated as support. On the other hand, their feedback focuses on the ostensive dimension of the routines as in the written report, such as guidelines, standard operating procedures, or checklists. The feedback remains abstract and identifies what requires adaptation but not how that may be achieved. The wording in the report itself (e.g., "removal" or "replacement") and the nurses' perception of being threatened illustrates this lack of providing suggestions of how to adapt caring routines on the performative

level. As Hector notes: “We need someone, who can provide us ideas on how to get better, who comes and really helps us in defining what we can do differently. Yes, I think the way of giving this feedback was not very humane.”

Third, Reho nurses hardly participate in their department’s development, namely, when accompanied in their daily work and when summoned to the feedback meetings. But they are excluded from the meetings between Herbert and Anton.

As a result, the meaning structures relate in the way of opposing each other. For the members of Laho, the goal was to adapt Reho’s nursing practice to that of Laho. The Reho nurses understood their work differently and interpreted Laho’s feedback sessions accordingly. Furthermore, the way of conducting the feedback resonated with Laho’s professional understanding but not with that of Reho where informal settings were common. Finally, Reho members were excluded from the continuous reflection of the change initiative and included as the executors of the measures defined elsewhere. In this respect, Laho’s activities of episode 1 appear as feedback. Feedback provides information to steer a system from the outside but is not integral to the system’s operating (see section 2.2.3.3, p. 47). The feedback thereby resonates with the conflict that surfaced the paradox of the different meaning structures.

6.2.2 Episode 2: Emergence of reflective routines

The second episode demonstrates the emergence of the three reflective routines “ward visits”, “open door”, and “leadership conversation”. Episode 2 ranges from Rachel’s arrival as the person responsible for all Reho wards until her appointment to become the new nursing director at Reho at the end of 2004.

6.2.2.1 Event history episode 2

The following account describes the events to stabilize the daily work at Reho’s nursing, as summarized by Figure 6-2.

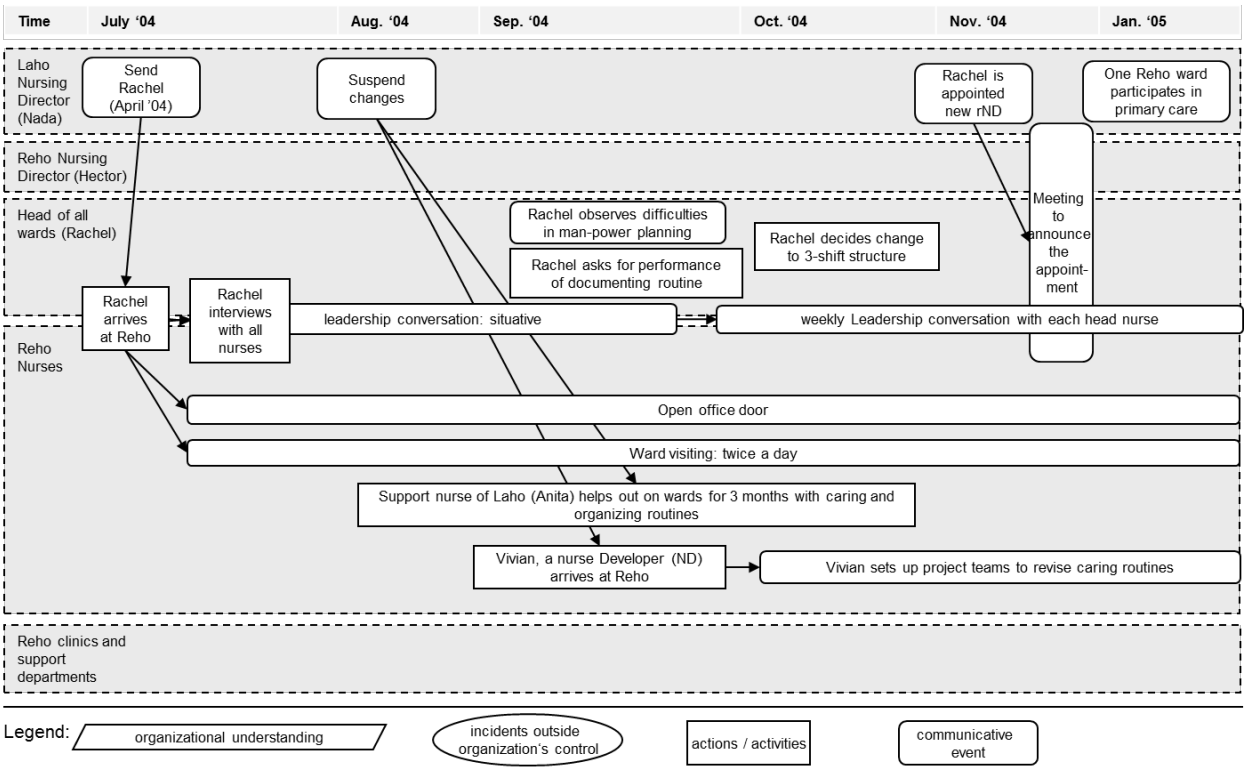


Figure 6-2: Integrating nursing, episode 2

In April 2004, Nada decides to deploy Rachel, a head nurse of Laho's internal medicine department, to Reho for a six-month period. Rachel is Nada's direct subordinate and part of Reho's nursing leadership team. Rachel is in charge of the wards. Her designated task is to conceptualize the implementation of nursing standards, to assess the level of personnel qualification as well as leadership, to develop a concept for advanced training, and to assist the wards in planning and organizing their daily work. After her stay, the Reho's nurses should continue the development by themselves.

On June 28, 2004, Rachel introduces herself at the monthly meeting of head nurses. When she commences work a week later, nobody seems to know her: "We thought, she comes, looks at what we can improve. That she comes to help us. … We have not been told of her official position - that she is our superior now" (Henrika, HN-1). Rachel feels that she is in the wrong place without access to Reho's documents in nursing, such as the duty roster, the monthly report, the guidelines, the checklists, and the documents on nursing standards. With this experience Rachel visits each team in their monthly team meeting, introduces herself, and explains the planned changes within the coming months.

During the summer of 2004, Rachel conducts interviews with all nurses "to see what the situation is, how they think about it, what their challenges are in their daily work on the wards with patients, with getting things organized and all that. It is important for me to

get their point of view, also how do they feel right now, what are the worries and fears, and hopes." She summarizes the results with the main topics, worries, and expectations.

Simultaneously, Rachel visits each ward in the morning and in the afternoon and explicitly leaves her office door open to invite her subordinates to approach her. In such situations, Rachel aims to provide fast support to the nurses' immediate problems. In addition, Nada grants Rachel a supporting nurse, Anita, for three months. Anita describes her own role as the "girl for every job", helping out in caring for patients, with documentation, and gathering care material or equipment.

For Rachel, the lack of ward leadership is a central challenge: "There is no leadership. It is all wishy-washy. Everybody does what she wants. And then it is not done, because nobody within the teams feels responsible." For Rachel, the leadership challenge also manifests in two organizing routines. One is the monthly manpower planning to ensure a ward's sufficient staffing. The other one is the comprehensive documenting of nurse activities. Documenting should occur in close proximity to when a care activity has been performed. Head nurses and Rachel need this data for manpower planning, budgeting, and handling different workloads between the wards.

Rachel addresses the leadership topic within the monthly wards' team meetings and encourages the nurses to discuss, decide, and implement certain topics collectively, while other topics will be decided by her. "And I think they accepted this, that there are some things, I decide, but others which I want them to decide." At the same time, Rachel begins meeting with every head nurse on a weekly basis—the so-called "leadership conversation"—to discuss topics related to running a ward, including manpower planning, documenting, personnel issues, or further training.

In August, 2004, Rachel and Nada decide to suspend the planned changes. In their view, sustaining the daily work on the wards takes priority. While many staff members are on vacation, the hospital admits a high number of often complex patients. In this period of high workload, a nurse informally explains that she and her colleagues have less courage to ask questions but rather aim to "get the job done somehow". Henrika (HN-1) would like to have time "with someone who reflects with us this whole situation." Likewise, Rachel notes that "everybody is so lethargic, they swallow everything. At the same time, they are over-worked. They spend their spare-time to fix arising problems just to keep everything running. You cannot work like this for long."

In September 2004, the position of a professional nurse developer (ND) is filled. Vivian's task is to revise and adapt the caring routines jointly with the nurses, following a professional understanding. She begins to assess various standard operating procedures and accompanies nurses in performing them. Some routines like waste disposal, pain treatment, and support in digestive relief require adapting the documents, which are published on the intranet in December 2004. For other care routines, Vivian organizes project teams to discuss and revise standards, such as wound treatment, food provision and support, or hygiene.

In October 2004, Rachel introduces the 3-shift work day and asks the wards to abandon their traditional portioned shift structure. This adaptation "reduces handovers and helps to clarify the responsibility a nurse holds for a certain patient" (Nada). All but one ward implements this shift. Elaine (HN-2) explains their exception: "Well, we changed the shifts a little bit so that we have less time overlapping between shifts. But then we were asked to quit our portioned shifts entirely, where someone works in the morning, goes home for lunch, and comes back to work until nightfall. We have tried it with the three shifts. But on my ward, it does not work. We are just such a small team."

In November 2004, Nada reaches an agreement with Martin, Reho's CEO, to replace Hector, the existing nursing director of Reho, with Rachel (see excerpt 1, p. 120). The decision is communicated to the nurses at the end of the month. Returning to the ward of HN-2 I visited during the week, the nurses informally discuss the topic. The change in personnel is not surprising to them, and the nurses appear slightly positive because they feared the end of Rachel's stay drawing near. Jill, a nurse, comments: "I am not surprised. This change has been in the air, and I think it might not be bad after all."

6.2.2.2 Three reflective routines in episode 2

In episode 2, three reflective routines emerge that are "ward visits", "open office door", and "leadership conversation". They express a shift from caring to organizational topics due to Rachel's observation of lacking leadership. After describing the reflective routines, follows the observed impact of Rachel becoming accepted by Reho nurses. Table 6-3 provides an overview of the reflective routines of episode 2:

reflective routine	Who	What	When	How
Ward visits	• Rachel • head nurse • present ward nurses	• whatever comes up as an immediate issue • non-immediate issue: strengthening head nurses	• regular: twice a day • duration: ca. 15 min. per ward	• unstructured conversation: "Are you doing OK"? • notes by Rachel
Open office door	• Rachel • whoever visits (ward nurses, head nurses, nursing developer; employees outside nursing unit)	• immediate issue brought forward by the visitor • non-immediate issue: strengthening head nurses, visitor's responsibility	• ad hoc; • varying duration (a few minutes up to half an hour)	unstructured conversation
Leadership conver-sation	• Rachel • head nurse of a ward	• respective ward: e.g. team leadership; personnel questions; tension between caring and organizing routines • concerns of and support for head nurse	• regular weekly meeting • duration: 1-2 hours	• limited structure: the head nurse's, and Rachel's concerns • no minutes, but individual notes

Table 6-3: Reflective routines during episode 2

In July 2004, Rachel begins *visiting each ward* in the morning and in the afternoon. These visits last for varying times depending on the surfacing issues. The visits occur in a seemingly informal, unstructured way. Observing several encounters reveal a similar pattern. Rachel enters the nurse office room and approaches first the head nurse with the question: "How are things going? Are you OK?" She converses with the head nurse over her issues of the day, including patient incidents, staffing, equipment, and the atmosphere within the team. Afterward, she includes the team's present members. At this stage, Rachel seeks to keep the head nurse by her side, sometimes gently linking her arm to hers. Inquiring about this observation, Rachel replies: "I want the head nurses to have a different, a more important position. I need them to be responsible for their ward, and they are my primary contact when I communicate with the ward. I want them to know what is going on in their team. And when I need to know something I want to ask them and not anybody else." Furthermore, the ward visits allow Rachel to make her own observations. "Going around and visiting the wards and teams regularly is sort of common practice for me. It is important for me to see for myself, so I visit all the wards, and take notes."

Second, explicitly keeping the *office door open* allows employees to feel free to approach Rachel by themselves. Knocking on the door, the visitor is invited in while Rachel interrupts her own work to attend to the issue brought up. These issues range widely. During 2004, they often include broken or missing equipment and infrastructure.

The conversations are unstructured and informal. However, I observe that Rachel sorts out with the visitor who should handle her issue. It can be the visiting nurse herself, as Rachel's helper Anita describes: "There calls a nurse to tell me that a hair shaver is broken. So, I tell her that we have technical support department. I give her the internal telephone number so that she goes there and gets it fixed." With other issues, Rachel refers the nurse back to her head nurse, such as requests for vacation, training, or conflicts among nurses. Rachel also handles a third group of issues that include collaboration between medical doctors and ward nurses, problems between patients' family members and the ward nurses, or difficulties in acquiring special equipment: "On one of the wards, they wait for a blood pressure gauge they have ordered half a year ago. Well, I got on the phone and had that fixed in five minutes."

Third, responding to the comment that "there is no leadership" on the wards, Rachel initiates the so-called "*leadership conversation*". This is a meeting of her with a single head nurse to discuss issues of running her ward. Started situatively, the leadership conversation becomes a weekly practice by October 2004 and is officially included in the nurse unit's structure on February 10, 2005, together with a day per week granted to the head nurse for pursuing organizational tasks. The leadership conversation lasts between 1 and 2 hours to discuss the issues of the respective head nurse and of what Rachel observes on the wards. These issues include, for example, equipment topics, personnel issues, team conflicts, and struggles with documenting nurse activities or with manpower planning. Furthermore, Rachel aims to strengthen the idea that the head nurses ensure documentation of care activities and to practice the manpower planning for their ward. On one such occasion in July 2004, I observed how a head nurse, her representative, and Rachel engage for two hours after work to define the duty roster for the following month of August. It appears to be a complicated task for all participants due to the team's high over time, varied part-time work contracts, and the requirement of highly qualified nurses to be present on the ward each day. Overall, the goal for Rachel is to strengthen the head nurse's position. Elaine, HN-2, recalls Rachel's surprise during their first conversation: "Rachel was surprised saying: 'what you cannot do this duty roster, the budgeting and all this?' No, we cannot do it, Hector did not allow us to do it and did it all by himself. He became our nanny."

6.2.2.3 Observed impact: Gaining acceptance within the family meaning structure

The observed impact of the second episode is that Rachel becomes increasingly accepted within Reho's nursing unit after the Reho nurses hardly noticed her when she arrived. Gaining acceptance was challenging with the recent experience of conflict. Another reason was that the family meaning structure gives priority to treating patients as the "real work", whereas other activities like meetings, conversations or handling organizational issues are not (see result section 1). As Henrika, HN-1, pointed out during the interview: "Sitting here with you in this interview, my team does not consider work".

Gaining acceptance for herself as a reputable professional and for her establishment of reflective routines resulted from several sources. First, addressing the expectation of support was essential for both the reflective routines and for Rachel to gain acceptance. Swiftly handling an immediate concern assisted Rachel to gain a positive reputation among Reho nurses in that it addressed their expectation "that she comes and helps us" (Henrika, HN-1). Once the employees recognize these benefits, the requests become overwhelming. In October 2004, Rachel laments: "I am the idiot for everything here right now, the nurses approach me with every little concern they have." For a couple of months, Anita therefore assists her: "I am just here to help out. I go to the wards and see what I can do. Helping with patients, documenting, looking for missing equipment … all these sort of things". Helping on immediate tasks assists to secure the fragile work situation, Rachel observed in August 2004. The fact that Laho granted personnel to handle immediate issues (Anita) and to systematically adapt care routines continuously (Vivian) may have fostered the development of gaining a reputation as a professional nurse who responds to the need of Reho's nursing. "We need someone who can provide us with ideas on how to get better, who comes and really helps us" (Hector, Reho's nursing director in episode 2).

Second, Rachel immersed herself in the local context. For her, it is important "to see for myself, so I visit all the wards, and take notes." Nada, her superior and nursing director of Laho, agrees: "You first have to experience before you can change." Through immersion, Rachel aimed to learn "how they [Reho nurses] feel, what are their worries and fears, and hopes". Immersion involved both a one-time interview series with all employees and continuous ward visits as well as keeping her office door open. In comparison, immersion during episode 1 was temporarily restricted.

Third, as an effect of local immersion, Rachel and Nada decided to suspend their change initiative and focus on stabilizing the existing work to uphold patient care during the summer of 2004 instead. According to Anita “it was quite clear this month that everybody is close to the edge. We have so many calls and requests for bagatelles that I could not believe that the nurses would call us for such little things.” Given the high workload Reho nurses reported in the narrative, suspending the change initiative presumably relieved Reho nurses to some extent.

During this episode, Rachel gains acceptance and the three reflective routines do as well. Instead of an outside feedback, these routines become integral to the nursing unit’s work because their performance supports the Reho nurses on their challenges. The emerging reflective routines allow the nurses to detect their daily challenges and act upon them.

6.2.3 Episode 3: Further differentiating and embedding reflective routines

This episode displays the further emergence of reflective routines and their embedding within the nursing unit. Episode 3 begins with Rachel as the new nursing director of Reho in February 2005 and ends in December 2005 with observing the last head nurse meeting of that year.

6.2.3.1 Event history episode 3

The following account focuses on the reflective routines that emerged during this time. The head nurse meeting changes considerably. The morning meeting commences for operative issues, and the meetings with heads of clinics are initiated. Meanwhile, the reflective routines from episode 2 continue. Figure 6-3 is a summary of these events.

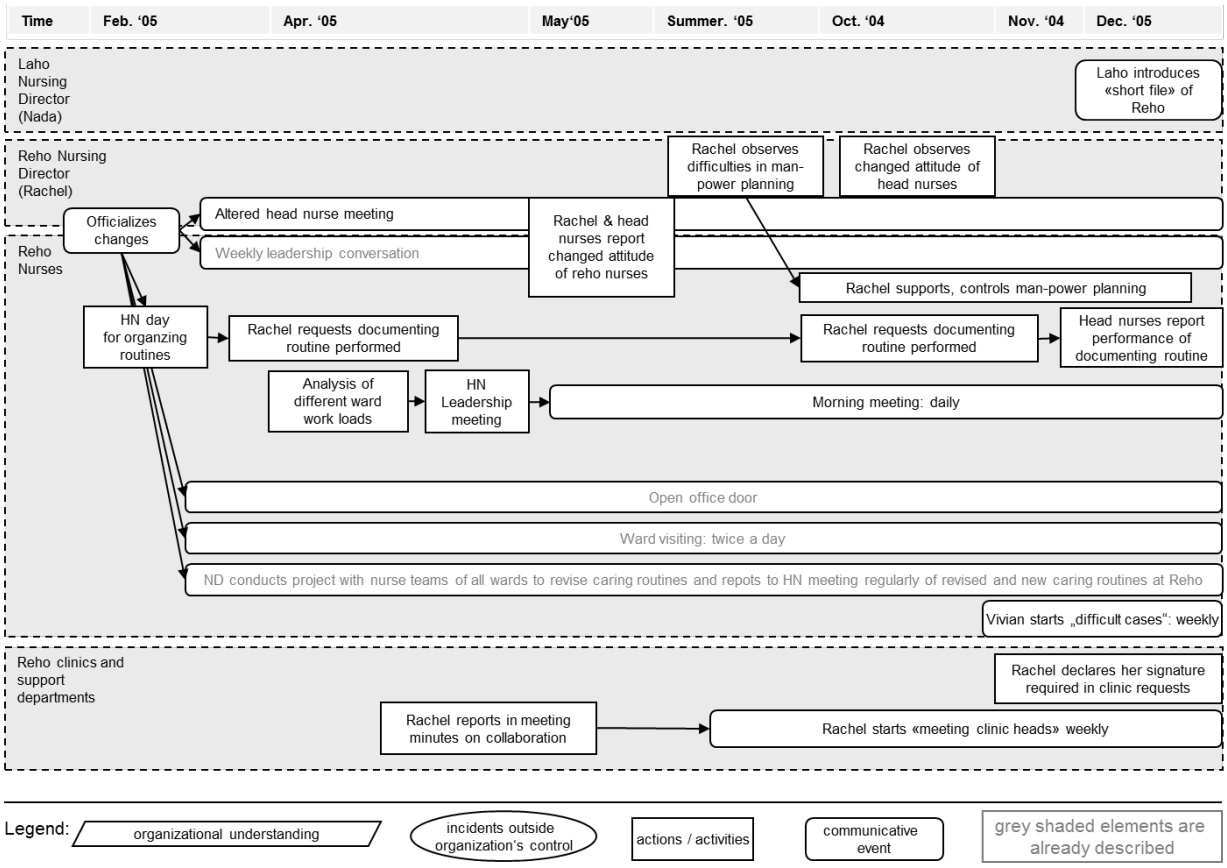


Figure 6-3: Integrating nursing, episode 3

With the altered leadership of Reho's nursing department, Rachel initiates changes from February 2005 onwards. Advanced training throughout 2005 includes team leading, management by objectives, and documenting nursing activities (April, 2005). Professionalizing nursing standards involves the preparation of the wards for the primary care concept (January to September, 2005) and the introduction of team meetings to reflect on difficult cases (November, 2005). Nursing teams across the wards work on these adaptations in close coordination with Vivian and her Laho unit of nursing development. Meanwhile, Rachel continues to visit the wards daily and leaves her office door open. Rachel and the head nurses continue the "leadership conversations", which are formally included into the nursing unit in February 2005.

On February 10, 2005, the new Reho nursing director leads the monthly head nurse meeting with the head nurses (Henrika, Elaine, Ulrika and Cheryl), the nursing developer (Vivian), and Hector (former nursing director of Reho). Rachel pursues the following aim: "I want that the head nurses engage themselves in the changes we pursue." This goal takes until May 2005 to be noticed within the nursing unit.

One change in the head nurse meeting is to invite guests and to allow self-invitations by other departments and clinics to the head nurse meeting. The invitation of guests emanates to the collaboration between departments. Over the year, the minutes of the head nurse meeting refer to this development: Collaboration is noted to improve with emergency care and ambulance (March 2005), while the minutes contain problems in collaborating with medical doctors. In July 2005, Rachel initiates weekly meetings with the heads of surgery and inner medicine to discuss emerging issues in daily collaboration before "*they grow and suddenly explode*" (Rachel).

At the head nurse meeting in March 2005, Rachel introduces the daily "morning meeting" after observing that wards observe different workloads. The daily morning meeting with the night shift nurses, Rachel, and the nurses responsible for the wards aims to share events of the night and the expected work for the day. The minutes of the head nurse meeting (March, 24th, 2005) state: "I [Rachel] aim to become faster in reacting to unexpectedly increased work load."

In May 2005, the head nurses observe and discuss what they call an "*attitude change*" within the ward teams. Ulrika, HN-3, observes in her team: "I have the feeling that now they can admit when an error occurred. They can stand there and say: ok, that happened. But also, they can stand their ground more firmly and argue. In total it has become more friendly and appreciative in our talking with each other on work issues on the ward. It is not with everybody, but I see it growing now." During my regular visits in the head nurse meeting, I notice a stronger engagement of the head nurses in the discussions of topics in May 2005 and a clearer focus on the nursing unit as a whole. In comparison, previous meetings bore the tendency to be filled with seemingly operative details, such as broken sinks or missing hair driers.

Over the year, the minutes to the head nurse meeting contain continuous observations about the changes, both in caring and in organizing routines. In caring routines, Vivian reports several revisions of nursing standards, including the creation of a so-called "short file", a patient file designed for short hospital stays. The short file is passed on to Laho, where Nada decides to have it introduced to all wards by 2006. Furthermore, the ward that was selected in January 2005 to participate in Laho's primary care project shares its experience in the head nurse meeting (September 2005). Finally, an external patient survey states that the performance of selected caring routines improved up to the level

similar to that of Laho. At the same time, I observe during episode 2 and 3 that the routines of manpower planning and of documenting care activities are regular topics in the head nurse meeting (see appendix 8.5, p. 216ff.). Their adapted performance remains difficult. While manpower planning remains challenging, the documenting routine improves. All but one head nurse report in November 2005 that they enact the documenting routine comprehensively and in a timely manner.

6.2.3.2 Three reflective routines in episode 3

During episode 3, I observe three additional reflective routines. Table 6-4 summarizes these reflective routines in the temporal order of their emergence.

Reflective routine	Who	What	When	How
Head nurse meeting	• Rachel (nursing director) • Hector (former nursing director) • head nurses, • Vivian, nurse developer (ND), • guests (as to topic: medical doctors, heads of other departments)	Nursing department : • internal cooperation among wards, • cooperation with clinics, other departments, • hospital initiatives • issues brought forth by the head nurses	• regular meeting every fortnight (since 02/05, before: monthly) for ca. 2 hours	• (1) general topics of nursing director (categorized along: informing, discussing, deciding (as group or by the nursing director) • (2) specific initiatives • (3) round of wards: topics of the wards; informing, bringing up topics • (4) closure • (5) documentation (artifact) distributed to wards, nursing director, clinics, hospital management
Morning meeting	• Rachel (nursing director) • night shift nurses • all nurses responsible for the wards	End of night shift: • incoming patients, significant events during the night • clarifying ward's workload • balancing workload	• daily meeting for 15 Min.	• reports of the night shift nurses • nursing director informs of planned workload (incoming and outgoing patients) • clarifying mutual need for "lending" nurses
Meeting medical doctors	• Rachel (nursing director) • heads of clinics (Anton, Martin)	• issues of collaborating between the nursing unit and the clinics	• weekly and ad-hoc meetings • duration varies	• presumably unstructured conversation focused on the issue at hand

Table 6-4: Reflective routines during episode 3

First, in the *head nurse meeting*, Rachel announces that it is becoming a reflective routine with the aim "that the head nurses engage themselves in the changes we pursue". Besides this focus on changing the nursing unit, the head nurse meeting is also supposed to serve to jointly reflect on the ongoing work. She describes: "Here, we can talk about problems on the wards or within the nursing unit as a whole. And I can gather opinions and perceptions of the head nurses of how work is coming along. Also, we can discuss

how we can help one another, so that the wards think more in relation with each other. And, when we discuss the projects or changes, we can share the experience, like the challenges each ward encounters and how they handle them."

The head nursing meeting is adapted in various ways. First, the temporal rhythm increased from once to twice a month. Second, the topics are aimed to shift from operational details of specific wards to issues regarding the nursing unit as a whole. Third, the internal meeting structure becomes clearer. At the beginning, the nursing director goes through general topics and now explicitly marks whether she informs the attendants, invites discussion, or asks for a decision. This is followed by reports on ongoing initiatives such as adapting caring routines before each head nurse contributes her concerns one after another. Fourth, the documentation of the meeting follows this structure and is completed shortly after the meeting. The minutes are distributed to all attendants as before, but now they are also distributed to all clinic and department heads and to Reho's CEO. Likewise, unlike before, a meeting agenda is distributed to this audience prior to the head nurse meeting. Fifth, guests are explicitly invited to the head nurse meeting and other departments are allowed to invite themselves. As an example, the head of Reho's kitchen attends the meeting in February 2005. He is invited because the nursing unit wants to change the meal times to better fit the 3-shift structure. The head of the kitchen explains the implications for his team, like changing schedules for cooking, delivering the meals and collecting the trays. The attendants of the meeting agree that the ward teams return the trays after lunch themselves.

The second reflective routine in episode 3 is the *morning meeting* that has been briefly described in the event history. The morning meeting addresses the daily challenges of wards and their work load differentials. Performed daily and with members of all wards, the morning meeting allows the participants to gain insights on the current workload of their own and of the other wards.

The morning meeting results from the head nurses observing differences in work load between the ward teams and also a certain "victim" attitude among nurses of a particular ward: "Well, if I take the ward of Ulrika (HN-3). They always have the feeling to be left behind and complain that they have too few nurses in their team but the highest workload. To me, they consider themselves victims. And my colleague, Ulrika (HN-3), tries to motivate her team to be more open and to leave that victim attitude. But it is not

easy" (Henrika, HN-1). Rachel has a similar impression but on another ward: "They (ward 2 of Elaine) often think: 'we poor things. We have so much work and the other wards have an easy day.'"

After assessing the work load of the wards in April 2005 and holding a head nurse workshop on managing the wards on April 19th that followed a training course on team leadership a week before, the "morning meeting" starts in May 2005. The head nurse meeting minutes of March 24, 2005 contains the following explanation: "The reason for the morning meeting is that all present in the morning shift are informed by the night shift about remarkable events, like emergencies, deaths, entry of patients etc. Also, I want that we all know each ward's daily work load… With this knowledge, I aim to become faster to react to unexpected increased work load." The morning meeting at 7am lasts for about 15 minutes and includes the night shift nurses, Reho's nursing director, and all the nurses responsible for ward teams.

The third reflective routine "*meeting clinic heads*" emphasizes the collaboration between them and the nursing unit. As part of professional caring, the nursing unit aims to shield itself from the instructions of medical doctors on organizational issues. While medical doctors are entitled to instruct on medical issues concerning patients, they have to discuss other topics with the nursing director. This shift resonates with a professional understanding at Laho in which the nursing unit is separate from the different clinics.

This change turns into conflict with the clinic of inner medicine. Martin, Reho's CEO and co-head of inner medicine, states: "That I have first to talk to her [Rachel] before being able to approach the wards did not exist here before. We now have to follow the chain of command, but that is not helpful to handle issues as they arise." Rachel explains her view: "I have to be so careful that the medical doctors do not just order my people around. You have to be alert all the time, and pick a fight sometimes, so that it is clear that the medical doctors approach me first when they want organizational changes on the wards".

In order to handle such issues continuously and in a timely manner, the "meeting clinic heads" provides the continuous space to reflect on and handle issues of collaboration. It takes place once a week, lasts for about 30 minutes, and includes Reho's nursing director and the respective clinic head. Later in the year, Rachel and the head of surgery report that their cooperation improved significantly, but the problem remains with inner

medicine. The minutes of the head nurse meeting (November 2005) contain a restatement of the instruction given to head nurses in July to refuse doctors' instructions on organizational issues. Cheryl, HN-4, mentions in November 2005 that a clinician tore up his notes and slammed the door when she asked him to approach Rachel with his request of changing the ward round times. Likewise, within the nursing unit, Hector, Reho's former nursing director, states in an interview in November 2005: "The collaboration with the clinics has become more difficult". One of the head nurses (Henrika, HN-1) remains ambiguous: "In general, I do not quite like the idea to separate the nursing department so strongly from the clinics. … But, at the same time, the experience we have sometimes is also true that the medical doctors just intrude in our work all the time. Sometimes, we have to distance ourselves a bit … But, we and the clinics should stay in the same tune."

6.2.3.3 Observed impact: the professional meaning structure becomes visibly enacted

In the third episode, both the researchers and the practitioners observe a shift in the organizational understanding of Reho's nurses: In May 2005, I notice a stronger engagement of the head nurses in the discussions of the topics and a clearer focus on the nursing unit as a whole, whereas prior meetings bore the tendency to become filled with seeming operative details. Rachel reports such a change with the head nurses in the meetings minutes in October 2005. The head nurses note and report a shifting attitude of their team members in May 2005 in the meeting minutes. "There is a new atmosphere here at Reho. It is not with everyone, but it is growing" (Ursula, HN-3).

The displayed data also shows that this shift does not mean that the professional meaning structure replaces the family one. Regarding the collaboration with medical doctors, Elaine (HN-2) appreciates some distance while questioning the separation, like Henrika (HN-1): "I do not quite like the idea to separate the nursing department so strongly from the clinics." Similarly, Hector, the former nursing director feels that "the collaboration with the clinics has become more difficult". Several head nurses mention the increased workload for them as a result of their enhanced engagement in task like ensuring documentation or manpower planning. Given these pieces of data, the meaning structure appear in parallel.

The double occurrence of the meaning structure also is apparent in the changes of caring and organizational routines during episode 3. On one hand, several caring routines

become adapted and an internal evaluation demonstrates their performance on a similar level, as in Laho. Furthermore, the Reho nurses develop a new nursing routine that Laho introduces as well. On the other hand, the routine of documenting care activities takes until November 2005 until the nurses consider it to be enacted in the new way. In comparison, the manpower planning routine bears mixed results in that some of the wards continue to practice it as before (see appendix 8.5, p. 216f).

6.3 Analysis: Reflective routines as outcome and as medium

The results section reports the comparison of the two meaning structures and how the change unfolded. The *first episode* ended with an open conflict. The paradox of the opposing meaning structures became salient. The *second episode* depicts how this situation was handled and reveals the emergence of reflective routines rather informally. The *third episode* shows the further development of reflective routines and their formalization within the nursing unit. Within this episode, the organizational members note the shift in their organizational understanding.

The following analysis mainly focuses on the latter two episodes and demonstrates reflective routines as outcome and as medium of the deliberate change attempt. The first episode provides a comparison to explicate the reflective routines and their emergence.

As an outcome, the comparison between the six reflective routines shows their differentiation according to topics, involved actors, temporal rhythm, and degree of visible structure. This differentiation leads me to the conclusion that the reflective routines as an outcome are integral to a continuous development of the nursing unit. As a medium and second, the establishment of the reflective routines involves four components. They range from individual observing to embedding the reflective routines officially within the nursing unit. Third, I identify favorable conditions that were created as non-routine activities and that resulted from the reflective routines. Fourth, these analytical insights lend to a process model of establishing reflective routines as both a medium and an outcome of the deliberate change attempt.

6.3.1 Reflective routines as outcome: Reflection of caring and of changing

Comparing the reflective routines shows that they differentiate along the themes Reho's nursing unit deemed important. The reflective routines reached out to all employees, occurred both ad hoc and at predefined times, and ranged from unstructured to formalized meetings. Before turning to these four aspects in more detail, their analysis implies that the differentiation of the reflective routines presumably provided an overall structure to avoid that either routine became overloaded with topics or participants, thus jeopardizing handling the situation at hand. Furthermore, the reflective routines presumably supported the stabilization of daily work. Finally, the reflective routines addressed both meaning structures in terms of the content and in terms of how they were conducted.

The following section with the comparison of the reflective routines draws on a distinction between feedback and reflective routines. Feedback "involves the generation of information about system conditions that flow back to the system to control it" (Feldman & Orlikowski 2011: 1242). Feedback is not integral to a system and its development but provides a temporary reflection on a phenomenon. In this respect, Laho's activities of episode 1 can be seen as feedback that is associated with a conflict that made the paradox of different meaning structures salient. In comparison, reflection also involves to observe a phenomenon, thus qualifying as a second-order observation (see chapter 2.2.3.3, p. 47). But in comparison to feedback, reflection is integral to the social phenomenon in which it takes place (Feldman & Orlikowski, 2011; Zundel, 2012).

6.3.1.1 Topics: Caring and organizing routines

The *topics of the reflective routines* encompassed the two themes central to the nursing unit at the time: caring work and tasks related to leading and organizing the wards. The first theme was to improve the caring work within the nursing unit. This topic was most obvious in the "morning meeting", "difficult cases", and the "project teams", which all explicitly concerned issues of nursing work. The second theme was to strengthen what Rachel called leadership and communication on and between the wards. This theme included explicit organizing routines like manpower planning and documenting nurse activities, leading personnel, and establishing the role of the head nurse within the wards along-side clarifying the role of the nursing director. Such topics were most prominent in the "leadership conversation", the "head nurse meeting", and the "meeting of clinic

heads". A mixture of the themes occurred in "open office door" and "ward visits", depending on whatever was brought to the attention in conversations between the nursing director and the ward members.

6.3.1.2 Actors: Reaching out to the nursing unit's members

The *involvement of actors* across the different reflective routines shows that they included all hierarchical levels of the nursing unit, and stretched beyond to important contact persons within Reho. The upper hierarchy of the nursing director and the head nurses participated in the "head nurse meeting", the "leadership conversation", and depending on their presence also in the "morning meetings." The Reho team nurses were included in "open office door", in "ward visits", and "morning meetings" and reached out to all three shifts of the nursing unit. Externals met either individually with the nursing director in case of "meeting clinic heads" or with the unit's upper hierarchy in the "head nurse meeting".

Through the varying participation, the reflective routines reach out to all members of the nursing unit and beyond. Including the members of the nursing unit is challenging because staff members are regularly absent throughout the day due to the 3-shift structure, varying part-time contracts, and accumulated over time. Overall, the reflective routines include the unit's members and provide the opportunity that they "engage in the change process" (Rachel with regards to head nurses, episode 3).

6.3.1.3 Temporal rhythms: Combination of ad hoc and planned repetition

In terms of *temporal rhythm*, the reflective routines took place ad hoc and in varying but previously defined times: ad-hoc interaction was integral to "open office door". Twice a day, Rachel visited the wards in the morning and in the afternoon, allowing for conversations with the first two shifts. Once a day, at 7 am, the "morning meeting" included the third shift during the night. The "leadership conversation" and the "meeting clinic heads" took place weekly, with the latter allowing for ad-hoc conversations. Every fortnight, the "head nurse meeting" was scheduled for Thursday afternoons.

The reliable rhythm allowed attending to topics of varying urgency and over a prolonged period of time. Reflecting turned into an ongoing and continuous part of daily practice that became integral to Reho's nursing unit. Furthermore, these rhythms help to create expectability of a structured work process throughout the nursing unit and complement

the already existing morning break within the teams. In this way, they address Herbert's observation of the "daily chaos" during episode 1.

6.3.1.4 Conduct: Between informal conversation and structured meetings

The *way of conducting* the reflecting routines appears in their varying structure. This structure ranged from informal conversations up to pre-defined meetings with an identifiable sequence accompanied by an agenda and meeting minutes.

There was hardly any observable structure in the "open office door" policy as an informal conversation. I did not observe the "meeting clinic heads", but interview data implies a structure driven by the issues at hand. During the "ward visits" I detected a subtle pattern of similar questions and approaching the head nurse first before engaging with the team while keeping her in range. Likewise, the "leadership conversation" contained two structuring components: the issues brought forth by the nursing director and the respective head nurse. In general, these meetings also appeared as a more informal conversation without an official agenda or documentation but with handwritten notes. A more explicit internal structure was observable in the "morning meeting" that followed a similar sequence of asking the night shift nurses for events on the previous nights, assessing the planned entrances and exits with the morning shift nurses, and elaborating within the meeting on how to handle them. An explicit structure was observable within the routine of the "head nurse meeting", which involved general topics of the nursing director, reports on current initiatives, and a round of topics raised by the head nurses. Each meeting was preceded by an agenda and followed by the minutes.

The internal structure of the reflective routines resonates with the different functions these settings fulfilled. The internal structure varied from informal conversations to a fixed sequence. Whereas informal conversation are known to be less restrictive to emerging topics (Baecker, 2005), more formalized meetings that included minutes help to declare decisions. The more informal settings assisted observing emerging topics. The more formalized ones supported the closure of issues by fixating how to proceed.

The differentiation of the reflective routines along topics, actors, temporal rhythm, and conduct meant that the members of nursing observed their daily work collectively. The reflective routines provide a second-order level of reflecting and subsequently acting upon these observations. In their differentiation, the reflective routines are a means to structure the daily work in terms of focus, time, and involvement.

6.3.1.5 Resonance of the reflective routines with both meaning structures

Furthermore, the differentiation of reflective routines *resonates with both meaning structures*. Whereas reflective routines were informal within Reho's family nursing, rather formalized settings are common in Laho's professional nursing. The resonance with the family meaning structure occurred in at least three ways and was most obvious during episode 2.

First, the immediate issues that were addressed in the open office door and the ward visits routine were those of the Reho nurses. In comparison, the identified deficits in episode 1 expressed the concerns of Laho's nurses and the professional understanding. Thus, in episode 2, Rachel addressed the Reho nurses' expectation of direct support.

Second, the routines of open office door, ward visits, and the leadership conversation are rather informal conversations that were similar to the private conversations common at Reho. During the first episode, feedback was conducted as a formal meeting.

Third, the location of the reflective routines refer to the family meaning structure, as ward visits (episode 2), and the morning meeting (episode 3) took place on the wards. In comparison, the feedback meetings during episode 1 were located remote from the nurses' work place at Reho's meeting room in the fourth floor.

At the same time, the reflective routines resonate with the professional understanding in three respects. First, reflective routines concern the challenge of lacking ward leadership that Rachel thought to be a central challenge. Issues brought up in the routines of open office door and ward visits provided an opportunity to distinguish with the participants whether the nurse should handle the issue herself or with her head nurse. Most explicitly, the leadership conversation was geared towards this topic.

Second, the temporal regularity and expectability resonated with a professional understanding, whereas temporal structures hardly existed within the family meaning structure, except for the wards' breakfast break at 9 am and the lunch break.

Third, the actual performance of the reflective routines expressed the importance of nurse leadership and organizational topics. They are "not considered real work" within family nursing (Henrika, HN-1).

Overall, the reflective routines resonated with both meaning structures. The ones of episode 2 associated with the family understanding as to how they were conducted. Those of episode 3 expressed the professional understanding.

6.3.2 Reflective routines as medium: Establishing reflective routines

As a medium, *the establishment of the reflective routines* reveals five components besides the differentiation of the reflective routines mentioned above. *During episode 2*, I detect individual observation through immersion in the local context; repeated interaction; and resourcing through swiftly addressing issues at hand. These three components are mutually reinforcing and occur in parallel: individual observing takes place during interacting with the nurses, while the interacting is regarded as helpful if individual observations lead to handling concerns. *During episode 3*, reflective routines differentiate further, and the reflective routines become embedded through their official declaration in the head nurse meeting and their documentation in the meeting minutes. The meeting minutes also serve as a means to continuously document the unfolding change initiative. The minutes are distributed inside the nursing unit, to the clinic heads, and to Reho's CEO.

In the following section, I elaborate on these components to depict the process of establishing the reflective routines. Although the sequence changed between the episodes due to the appointment of Rachel as the nursing director, the components were performed throughout both episodes. They all appear to be integral for establishing the reflective routines. Figure 6-4 provides an overview on the four components (except for the differentiation which is the subject of the previous section) and on the resourcing through immediate support.

	Episode 2			Episode 3		
Reflective / Components	**Visiting Wards**	**Open office door**	**Leadership Conversation**	**Head nurse meeting**	**Morning meeting**	**Meeting clinic heads**
Individual observing	Rachel: «Are you OK?»	Rachel and nurses	lack of ward leadership	none (reported)	Rachel, head nurses observe work load differences	head nurses, experts, Rachel observe difficulties
Repeated interaction	twice a day	situative, ongoing	weekly	fortnight	daily (but after formalization)	weekly
Resourcing through immediate support	responding to the issue at hand; reinforcing ward leadership		office day for head nurses	internal structure of the meeting, agenda and meeting minutes	analysis of nurse activities, workshop and training	creating public through documenting Published instructions to ward teams
Embedding … through formalization	none	none	after establishing its performance	in the moment of performing	before performing	before performing
… and through distributing documented observations	informal notes of nursing director		informal, notes of nursing director and head nurse	meeting minutes, distributed to clinics, Reho leadership	initiation and reasoning in minutes	none, but topics reported in head nurse meeting

Figure 6-4: Components for establishing reflective routines

6.3.2.1 Individual observation through immersion in the local context

The first component is observing emerging issues. *Observing* is an ongoing activity throughout all three episodes and an important condition to detect potential challenges to the further development and to enable those responsible to act accordingly (Zundel, 2012). During episode 1, observing occurred as Mandy and Herbert accompanied Reho nurses in their daily treatment work. Likewise, from episode 2 onwards, the nurse developer Vivian continued this practice. Vivian describes it as part of her task as nurse developer, a notion appreciated also by some Reho nurses: “We need to develop this culture of reflecting our work, also among each other, when two nurses are at the bed-side with the patient so that they can tell each other: ‘hey, this and that you could do better.’” While these observations mainly concerned nursing work, Rachel commenced her time with the daily ward visits and by leaving her office door open. Here, she also detected topics regarding the teams, personnel, infrastructure, or ward leadership. In sum, continued observing allows the detection of emerging issues, which may trigger further investigation like the work load differences between the wards that preceded the introduction of the morning meeting. Likewise, meeting clinic heads followed the observation of challenges within the collaboration of the nursing unit with the clinics.

6.3.2.2 Repeated interaction

The second component is to perform the emerging reflective routine repeatedly with others. *Repeated interaction* creates expectability and recognizability of the emerging pattern (Feldman & Pentland, 2003). Starting during episode 2 with visiting wards and

keeping the office door open, reflection was practiced repeatedly. As pointed out above, the temporal repetition varies between the different reflective routines. Their repetition creates rhythm for those involved. Depending on the reflective routine, repeated interaction fosters reflection both on a broad range of issues (ward visits, open office door) or on a specific topic (ward leadership, collaboration with clinics, morning meetings). Through their focus and their expectable repetition, such actions become recognizable patterns and help to channel arising issues. Repeated interaction with the (later) nursing director indicate the significance nursing leadership attributes to these issues even before a reflective routine like the leadership conversation is introduced formally through a documented declaration in the head nurse meeting.

6.3.2.3 Resourcing through immediate support

As a third component, reflective routines require *recognizable consequences* in order to enhance their acceptance in the eyes of the participants (Reay et al., 2006). As pointed out at the end of episode 2, gaining acceptance was challenging because meetings do not count as "real work" in the family meaning structure. At the same time, Reho nurses expected support in their daily work. Addressing this expectation by handling the concerns of Reho nurses enhanced Rachel's reputation and showed the benefits of her ward visits, open office door, and leadership conversation, albeit she became overwhelmed with requests at times. At the same time, handling the nurses' concerns provided an opportunity to address Rachel's view of "lacking ward leadership". In her conversations with nurses, Rachel focused on sorting the topic in terms of responsibilities: the nurse herself, her direct superior, or the nursing director. In the past, Elaine (HN-2) noted "Hector did not allow us to do it and did it all by himself." Correspondingly, Rachel observed the Reho nurses during this period: "They only react to whatever comes along. They do not act. They do not question anything. They just accept things on first glance." The immediate concern provided an opportunity to counteract this observation and to foster "them [the head nurses] to be responsible for their ward".

The tangible benefits to the Reho nurses enhanced the acceptance of the reflective routines. Immediate support thereby complements individual observation through immersion in the local contact and the repeated interactions. Together these components foster the emergence of the reflective routines.

6.3.2.4 Embedding: Formalizing reflective routines and distributing observations

The fourth component to establish reflective routines regards their direct embedding within the organization. One aspect is their formal declaration in the head nurse meeting. The other aspect is to document and distribute these declarations as well as the reflections on the change process by the nursing unit.

Regarding the first aspect, most of the reflective routines gain a formal status, particularly during episode 3. The leadership conversation becomes formalized in February 2005. Rachel declares to initiate the morning meeting in March 2005. The adaptations within the head nurses meeting are clarified in February 2005 and performed in the meeting conduct. In comparison, the routines of ward visiting and keeping the office door open are not officially decided nor mentioned in the meeting minutes. Nor is the routine of meeting the clinic heads. But enhancing the collaboration between the nursing department and the clinics is a frequent topic of the meeting minutes.

The second aspect is the consistent use of the head nurse *meeting minutes to document the changes* that the members of the nursing department observe. This documentation in the official minutes congratulates the accomplishments and critically reminds that for example the documenting routine is still not observed to be practiced professionally (see appendix 8.5, p. 216). Documenting the changes in this way may foster acknowledgement and reinforcement to members of the nursing department to continue developing their practice of the routines in question. Beyond the nursing department, the documentation of topics regarding collaboration makes these issues available to the wider Reho public of clinics, departments, and Reho's management. The minutes contain positive notes on collaboration with departments like the kitchen, emergency service, or the clinic for surgery. The minutes also document the continued struggle with inner medicine. Through the organization-wide distribution, the struggle and the enhanced collaboration both tend to become a public affair.

In summary, the official declaration of reflective routines and the continued documentation of the unfolding changes seem to have reinforced the change process.

6.3.3 Enacting conditions: Non-routine activities and reinforcing effects

In order to establish the reflective routines and to move the deliberate change initiative forward required several important conditions, some of which are non-routine actions and others are reinforcing effects of the reflective routines.

Among the non-routine activities to enhance favorable conditions are investments at Reho, the lack of time pressure, and Rachel's professional background at Laho, besides the interview series with of all employees at the beginning of episode 2. First, Reho's nursing received *resources*. Personnel resources included Anita as a temporary support and Vivian as a permanent one. They demonstrate Laho's investment into the nursing unit early on during episode 2. Later, in episode 3, other investments become visible with setting up the Adipositas center (see chapter 4, p. 80, and chapter 5, excerpt 4, p. 126) or a day clinic for chemotherapy, both of which are new treatment areas at Reho. Also during episode 3, Laho's nursing department offers further training to Reho nurses, mainly on issues of ward leadership, thus noting the preferred focus of the future development. Fostering the professional meaning structure, Reho's nursing unit also provided head nurses their office day equivalent to 20% of their work time. Second, I did not detect that the integration of Reho's nursing into that of Laho followed *pre-defined deadlines*. Rather, and in line with the other clinics (see chapter 4), Laho's executive board (see chapter 5) allowed for the integration to evolve at its own pace. This lack of time pressure allowed suspending the planned changes during episode 2, signaling a caring attitude of Laho's nursing to that of Reho. Third, *Rachel's background* at Laho contributed to the favorable conditions. She had the experience that and how the professional meaning structure works.

These conditions further assisted the change initiative and the establishment of the reflective routines. At the same time, the establishment of the reflective routines themselves reinforced this development. First, the swift support on issues at hand enhanced the legitimacy of both the persons involved (Rachel, Anita, and Vivian) and the reflective routines they initiated. Showing visible support was crucial during the initial stages in episode 2. Second, the reflective routines supported that the Reho nurses take into account the other wards and the nursing unit as a whole. The morning meeting served to see the work situation of one's own ward in relation to that of the others. Differences in perceived work load could then be handled while simultaneously offering

a more collective view between the different wards. In a similar way, the head nurse meeting attended to the nursing unit as a whole with its revised structure and focus. Seemingly operative details of specific wards such as missing equipment were now handled in the open door routine or the ward visits. In these ways, the array of reflective routines reinforced attention to the nursing unit as a whole and to its different wards. A third reinforcement effect could have resulted through the documenting of the observed changes. The timely meeting minutes contained the head nurses' views on how the changes developed. As Reho's clinics, departments, and upper management received the minutes, the observations on the changes could become a more public affair. They bore the potential to reinforce the development, for instance, by demonstrating that the collaboration with other clinics worked well with one but not with the other.

6.3.4 The model "routinizing reflection"

The analysis of the reflective routines as both outcome and medium for deliberately shifting towards the professional meaning structure lends to a model of establishing reflective routines (Figure 6-5). The components of individual observing through immersion in the local context, repeated interaction, differentiating, resourcing through immediate support and embedding reflective routines in the center of Figure 6-5 explicate how the reflective routines emerged in this case. The reflective routines of the episodes 2 (Table 6-3) and 3 (Table 6-4) encompass an array of different contents, participants, temporal rhythms and internal conduct. Thereby, the reflective routines provided a means to deliberately change the nursing department. This change is visible in the shift from the family towards the professional meaning structure, represented by the upper and lower oval in the figure.

The establishment of the reflective routines first involved observing emerging issues through immersion in the local context. By repeating such interactions (arrow 1) on the wards and with the employees and head nurses, the reflective routines became recognizable patterns. Addressing and handling the challenges of the participants reinforced the acceptance of the reflective routines and of the actors involved (arrow 2). According to the emerging issues, the reflective routines became differentiated (arrow 3) into settings with different temporal rhythms, participants and varying degrees of pre-defined structures. This mixture helps to address issues of varying urgency. It creates rhythm through expectable temporal structures with simultaneous flexibility (arrow 11).

Furthermore, individual observing becomes collective through the reflective routines. Embedding the reflective routines involves their formal declaration, their official documentation, and that of the observed changes (arrow 12). The documentation is distributed both within the unit and beyond to important contact partners. The distributed documentation fostered that these decisions and changes turn into a more public affair (arrows 4, and 5). Figure 6-5 depicts this process as a model of establishing reflective routine, which I call "routinizing reflection".

The model depicts the components and the resonance of the reflective routines with both meaning structures. The enacted meaning structure provides the reference as to how participants interpreted the activities (see episode 1, section 6.2.1), indicated by arrow 6. Therefore, performing activities to become routines need to associate with the enacted meaning structure and did so, particularly during episode 2 (arrow 7, see Table 6-3). At the same time, the reflective routines were associated with the proposed meaning structure during episode 2 (arrow 9) but also during episode 3 due to Rachel's background, the goal of the nursing integration, and the focus and conduct of several reflective routines (arrows 10).

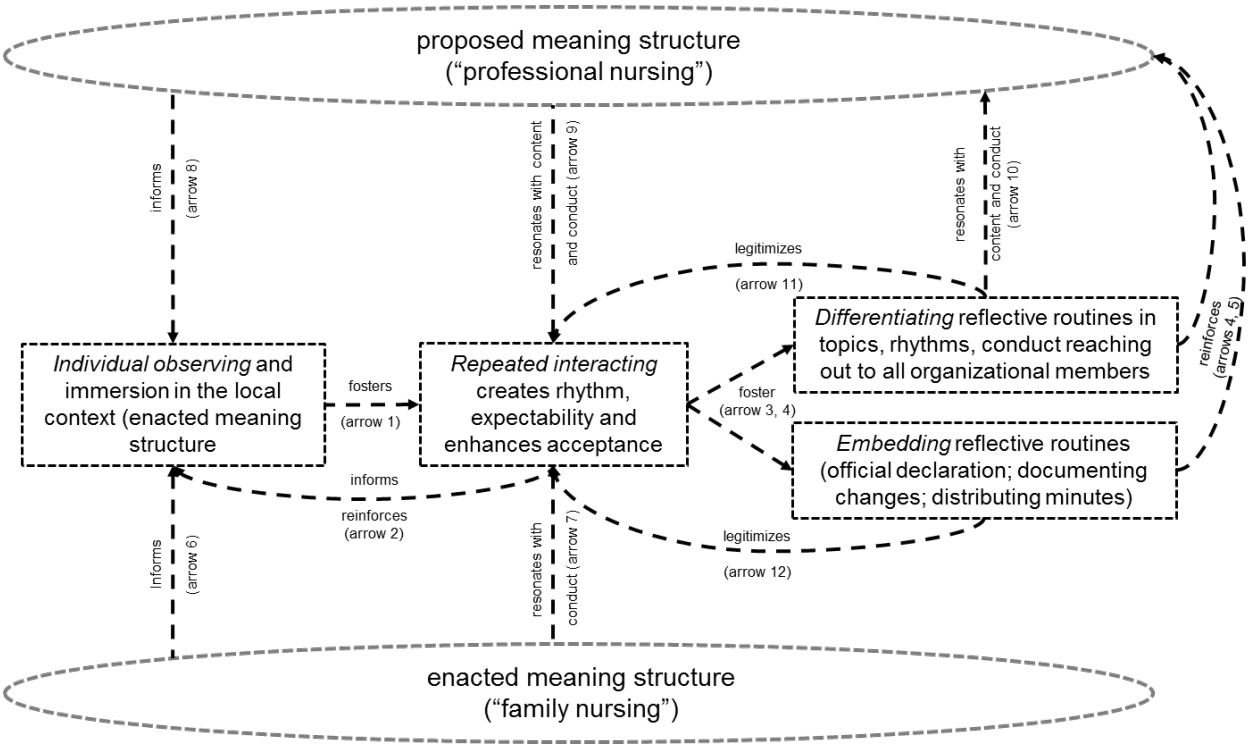


Figure 6-5: Model of routinizing reflection

This model of routinizing reflection comprises the explanation of how the deliberate change as the nursing unit unfolded over time. First, this model draws on reflection as integral to an organizational phenomenon (Feldman & Orlikowski, 2011; Zundel, 2012). Reflection is a second-order observation and part of accomplishing what we call an organization. Reflection occurs continuously during routine performance (Feldman, 2000; Feldman & Pentland, 2003), and the question then is how to routinize reflection as a collective achievement in order to move an organization forward. Along these lines, studies reporting successful hospital changes emphasize the importance of reflection, both as a temporary component of a change initiative (Edmondson et al., 2001) or as a routine to continuously develop clinical practice (Iedema & Carroll, 2011). Furthermore, reflective routines require that the handling of issues are visible to those who are on the receiving end of a deliberate change initiative (Reay et al., 2006). Such swift solutions generate the capacity to act within a situation (Feldman, 2004). Establishing reflective routines is therefore a matter of performing them while simultaneously establishing the respective understanding of such a routine (Pentland & Feldman, 2008). Furthermore, the double resonance expresses that reflection is integral to the social context in which it takes place and which it aims to alter.

Second, this model draws on the notion of self-referentiality or mutual constitution (Feldman & Orlikowski, 2011; von Foerster, 1984), which is integral to the paradox lens (Lewis & Smith, 2014; Smith & Lewis, 2011). The self-referentiality comes to the fore when the meaning structures turn into opposition (Lewis, 2000). This conflict emerges from how the meaning structures relate with one another. When participants interact in such a way that they each interpret the other's meaning structure from their own view, conflict becomes a probable result (Westenholz, 1993). In order to alter a meaning structure, the reflective routines need to establish themselves first within that very meaning structure by associating with it. Changing a meaning structure occurs from within the meaning structure. The establishment of reflective routines provides a means to this bootstrapping challenge (Barnes, 1983; Czarniawska, 2008). This is why the reflective routines are both the medium and part of the outcome to a deliberate change initiative. The reflective routines provide a means to handle the self-referentiality involved that leads to the salience of paradox during change. This view moves beyond the processual understanding of reflection proposed by Zundel (2012). He suggests reflection as a management by walking around but without elaborating on how

individual reflection becomes collective. In addition, without visible consequences of the reflective routines that address the challenges observed, reflection risks paralyzing action (Czarniawska, 2008). For these reasons, routinizing reflection becomes important.

6.4 Discussion: Routinizing reflection to embed paradox solutions in a pluralistic organization

The model of routinizing reflection depicts the establishment of reflective routines as both a medium for and an outcome to handle the salient paradox of opposing meaning structures. This model addresses the current struggle observed in the paradox literature that is the embedding of solutions to a paradox (see section 2.2.3, p. 42ff.). This model contributes to the paradox lens in four ways.

First, the model offers insights into *how* reflective routines are established, thereby complementing existing literature that highlights *that* active reflection on paradox is essential and how organizational members make use of such settings.

Second, the model draws attention to how the *meaning structures relate* during the establishment of reflective routines. The double resonance with both meaning structures enables to shift the proposed meaning structure into the foreground, while the enacted one moves into the background.

Third, the establishment of reflective routines *collapses the separation* of those organizational members generating paradox solutions and those who are supposed to enact these solutions. Therefore, reflective routines assist in handling the challenge of different meaning structures as references for interpretation, which tends to hamper the embedding of paradox solutions.

Fourth, the model of establishing reflective routines implies that *generating and enacting paradox solutions occur simultaneously* rather than as a sequence of the former preceding the latter. Furthermore, the empirical insights and the resulting model address the recent interest in routine emergence and deliberate change of routines. My findings therefore contribute to the deliberate change of routines that complements the common interest of routine dynamics in the situative and local enactment of the organization.

6.4.1 The process of establishing reflective routines

First, the model of routinizing reflection depicts the process of how reflective routines become established. The paradox literature emphasizes the importance of reflection when organizational members engage with paradoxes. Westenholz (1993) calls for the possibility that organizational members can reflect on paradox. Jay (2013: 138) argues "that active reflection on organizational paradox, by both scholars and practitioners, will result in our better understanding processes of change." Luescher & Lewis (2008) show the significance of reflection in order to generate alternative solutions to perceived problems by middle managers. Jarzabkowski et al. (2013: 261f) mention cross-sectional teams that adjust to opposing interests and elaborate on taken-for-granted assumptions. The managers in Smith (2014) highlight the importance of continuously interacting with organizational members on paradoxical tensions and their solutions. These and other studies (Edmondson et al., 2001; Iedema & Carroll, 2011; Kellogg, 2011) show how the involved actors make use of reflection in order to develop workable, temporary solutions to paradoxes.

However, the literature hardly addresses how such reflective routines emerge. The model of routinizing reflection addresses this niche and builds on the insight that reflection is ubiquitous (Brannick & Coghlan, 2006; Holland, 1999) and occurs continuously when organizational members perform routines (Feldman, 2000).

The model of routinizing reflection complements the paradox literature that highlights the importance and the use of reflection. Kellogg (2011) provides a concept of "relational spaces", which is similar to routinizing reflection. In her study, relational spaces offered the explanation for why certain hospitals implemented a deliberate change initiative successfully, while others failed. Relational spaces are informal reflective routines in which organizational members relate with one another, reflect on a deliberate change initiative, and coordinate their actions. The model of routinizing reflection is similar in this respect but different in the following four aspects. First, relational spaces are formed bottom-up by organizational members who are in opposition to a dominant group. In comparison, routinizing reflection was an integral component to the change initiative and initiated by the (later) nursing director. Second, routinizing reflection encompasses several reflective routines, whereas relational spaces are a single routine. Third, reflective routines became officially declared and thereby formalized, whereas

relational spaces remain informal. Fourth, relational spaces draw on the opposition between two groups and provide a means of the less powerful one to form itself. Routinized reflection aims at overcoming this opposition.

The model of routinizing reflection shows the emergence of reflective routines that organizational members employ to generate solutions to an observed paradox. It therefore addresses the current open issue of how to embed paradoxical solutions.

6.4.2 Resonance with the poles of the paradox

The second contribution is that the reflective routines associate with both meaning structures as the poles of the paradox. Particularly during the early stages, the reflective routines are associated with the enacted meaning structure in terms of their content and their conduct. Addressing the challenges of organizational members responded to their expectation of support within the enacted meaning structure. The informal conduct resonated with their practice of reflective routines. At the same time, addressing the members' challenges provided the opportunity to introduce themes of the proposed meaning structures. During the later part of the change process, more formalized reflective routines became established that resonate with the proposed meaning structure in terms of their conduct. Therefore, the initial resonance of reflective routines with the enacted meaning structure is complemented by and over layered with relating reflective routines to the proposed meaning structure.

The process studies on handling paradoxes attend to the opposing poles or meaning structures on a content level. The organizational understandings generated in Jay (2013) develop over time to first address one, then the other and at the end both organizational understandings. Luescher & Lewis (2008) report on solutions to paradoxical tensions experienced by middle managers that aim to associate the opposing poles. Smith (2014) and Andriopoulos & Lewis (2009) elaborate on managers' framing issues as integrative in order to relate the poles of exploration and exploitation. Abdallah et al. (2011) also points out the risk of diluting these solutions in later stages.

This literature hardly attends to the ways of enacting meaning structures or paradox poles, respectively. As a consequence, these studies hardly take into account the relation of meaning structures in terms of how they are enacted. Relating these ways of acting is

particularly relevant in pluralistic organizations because the ways of acting are manifold and contradictory (see chapter 4). With their focus often on senior (Abdallah et al., 2011; Andriopoulos & Lewis, 2009; Jay, 2013; Smith, 2014) or middle managers (Jarzabkowski et al., 2013; Luescher & Lewis, 2008), these studies take into account the respective group's ways of acting. These works hardly consider the patterns of those on the receiving end of paradoxical solutions.

At the same time, paradoxes are enacted locally and situatively (Clegg et al., 2002). The poles express contradictory contents (Lewis, 2000) and are enacted differently. For example, exploring evokes a different practice than exploiting (Andriopoulos & Lewis, 2009), making art (or health care) a different one than becoming economically efficient (Abdallah et al., 2011) or a scientific laboratory than a business (Jay, 2013). Therefore, leaving both poles intact implies not only to relate their contradictory content but also their respective ways of enacting these contents.

The proposed model of routinizing reflection is sensible to the dimensions of different contents and ways of acting. As I showed empirically, the emergence of reflective routines resonated with the enacted and the proposed meaning structure in terms of the topics and in terms of enacting these topics. As part of the change to shift meaning structures during episodes 2 and 3, the association with the proposed meaning structure over-layered the resonance with the enacted meaning structure. In comparison, episode 1 displays a disassociation between the proposed and the enacted meaning structures, which associated with misunderstanding and open conflict.

This contribution of relating opposing poles in terms of their content and their different conduct is particularly relevant when embedding paradox solutions. During such a deliberate change, the resonance with the enacted meaning structure helps to enhance the legitimacy of the proposed one. For example, direct support known as "small wins" (Barrett et al., 1995; Reay et al., 2006) enables the respective actors to generate resources to further pursue the proposed meaning structure (Feldman, 2004). Generating such resources can take time as in my case because it means to handle the challenge that the proposed meaning structure is interpreted from the perspective of the enacted one (Bartunek & Moch, 1994; Westenholz, 1993). Therefore, embedding paradoxical solutions requires relating with the opposing poles in terms of their contradictory contents and their respective ways of acting.

6.4.3 Collapsing the separation of the involved actors

The third contribution is that routinizing reflection overcomes the separation between the designers and implementers of a paradox solution. The proposed model depicts the establishment of reflective routines that includes the actors responsible for the change initiative and the handling of the paradox as well as the actors who are supposed to alter their work routines. In comparison, the paradox literature places a strong importance on the senior leaders (Ford & Backoff, 1988). "Organizations emerge as *leaders* respond to foundational questions, constructing boundaries that foster distinctions and dichotomies." (Smith & Lewis, 2011: 388, emphasis added). Being involved in the creation of paradox, senior leaders hold "substantial responsibility to enable the interplay between differentiated efforts and see more holistic synergies between the strategies" (Smith & Lewis, 2014: 131). Accordingly, researchers focus on the capacity (Denison, Hooijberg, & Quinn, 1995) or the practices of differentiation and integration senior leaders employ (Andriopoulos & Lewis, 2009; Smith & Tushman, 2005) in order to sustain the relation of the opposing poles (Smith, 2014), including the diluting effects of their own actions (Abdallah et al., 2011).

In these empirical studies, the organizational members who are to implement the resulting changes are hardly considered in generating these solutions. Luescher & Lewis (2008) focuses on the middle managers but does not include their subordinates in the process of paradoxical inquiry. Jarzabkowski et al. (2013: 263) mentions meetings of senior and project managers as one of the procedures that assist the emergence of a both-and approach to solve the opposition between departments. These insights suggest the importance of overcoming the separation between those generating and those enacting the solutions to paradox. Keeping these two groups separate evokes the risk that paradoxical solutions are interpreted on the basis of the organizational understanding which the solution aims to alter (Westenholz, 1993). As in episode 1, a similar separation associated with the conflict between the actors and the meaning structures. Therefore, the separation of the two groups helps to explain the current struggle of implementing paradoxical solutions.

As a starting point, reflection is important with paradoxes (Jay, 2013; Luescher & Lewis, 2008) and ubiquitous to routine performance (Feldman, 2000; Feldman & Pentland, 2003). Establishing new and adapting existing reflective routines within the organization

helps to overcome the separation between the ones generating and the ones enacting paradoxical solutions. The model of “routinizing reflection” extends reflection across an organizational unit by differentiating reflective routines, which include the different organizational members in order to establish reflection as an ongoing observation oriented towards those issues deemed important. Routinizing reflection thereby moves beyond the call for “a forum for discussion where carriers of reference could meet and discuss” (Westenholz, 1993: 54). It extends from settings of both senior and project managers (Jarzabkowski et al., 2013: 263) or those that focus only on the senior (Jay, 2013) or on the middle managers (Luescher & Lewis, 2008), who are said to be responsible for generating paradox solution.

By collapsing the separation, the challenge of differing understandings becomes visible when attending to specific topics within the different reflective routines as they arise. They offer the possibility to address them early on in a way geared towards handling the specific situation rather than allowing issues to combine and add up.

6.4.4 Simultaneous development and enactment of solutions

The fourth contribution is that the model of routinizing reflection suggests that the generation and enactment of paradox solutions occur simultaneously. The literature on paradoxes contains important insights, first, on the solutions to paradoxes and their perceived impact on reproducing paradoxical tensions or on enabling sustainable alternatives (Lewis, 2000; Smith & Lewis, 2011). Second, and in generating such solutions, we learn from Luescher & Lewis (2008) about the different steps of paradoxical inquiry to arrive at a temporary solution, while Jay (2013) shows a continuous engagement on paradoxical tensions as sensemaking. Third, recent studies show the effects of such actions. They may lead to further sensemaking (Jay, 2013), to reproducing the paradox and its relation to other paradoxes (Jarzabkowski et al., 2013), to undermining itself over time (Abdallah et al., 2011), or to the ongoing struggle to embed paradoxical solutions within the organization (Smith, 2014).

Most of these studies tend to suggest a sequential view. A paradox once salient invites managers to reflectively generate a temporary solution followed by embedding this solution within the organization. As a result, the embedding of the solution may evoke a further cycle of this sequence.

In comparison, the model of routinizing reflection and the presented data suggest that generating and embedding reflective routines occur simultaneously. In this respect, the model of routinizing reflection resonates with the notion of improvisation (Clegg et al., 2002), which indicates to plan while acting (Weick, 1993), similarly to Pentland & Feldman (2008), who argue for the importance of performing a new routine along-side designing a new understanding of that routine.

The model of routinizing reflection complements the processual view of Jay (2013) by extending his focus of the top management team to the organizational members that are to realize the envisioned changes. By doing so, the sequence of first envisioning a solution before implementing it turns into a process of simultaneously designing solutions and enacting them. A similar approach can be detected in the cross-sectional teams reported by Jarzabkowski et al. (2013: 261f) in order to "adjust" different interests of the involved actors. My model elaborates on this stage empirically and thereby illuminates further how adjusting emerges within the organization. In this respect, routinizing reflection moves beyond the individually triggered interactions of managers with employees (Abdallah et al., 2011; Smith, 2014) to establish reflective routines as integral to the organization.

Establishing reflective routines provides the paradox literature an alternative to the suggested sequence of envisioning and implementing paradox solutions. Simultaneously enacting and thereby designing reflective routines as paradox solutions corresponds with the self-referentiality from which paradoxes emerge and provides the context in which paradoxical solutions occur. Furthermore, this simultaneity implies that the responsible managers attend to the establishment and development of reflective routines so that the organizational members can envision and enact paradox solutions.

6.4.5 Routine dynamics: Deliberate change of routines and situated change

Routine dynamics provided a promising perspective. At the same time, the empirical insights and the model of routinizing reflection offers inspirations for routine literature that becomes increasingly interested in the emergence of routines (Parmigiani & Howard-Grenville, 2011) in general and their deliberate change in particular (e.g. Bapuji et al., 2012; Feldman, 2003; Stiles et al., 2015).

To the latter topic, my empirical insights and the model of routinizing reflection offer three aspects: First, *deliberately changing routines implies the salience of the paradox* that contains the potentially opposing poles of the enacted and the proposed meaning structure with which a routine associates (Rerup & Feldman, 2011). Actors turn to their organizational understanding in order to generate a shared reference to come to terms with the enacted and the proposed routine (Feldman, 2003). In the case of different organizational understandings, deliberately changing routines turns into a paradoxical endeavor. Changing routines requires simultaneously shifting the organizational understanding and the routines that express and draw on it. This paradoxical challenge has not yet been addressed within routine dynamics literature but appears integral to it because of the self-referentiality on which routines are based (Cohen, 2007; Dionysiou & Tsoukas, 2013; Feldman & Orlikowski, 2011).

Second, in handling this paradoxical challenge, the model of routinizing reflection *attends to deliberately changing routines*. Recent studies explore the change of single routines within one meaning structure (Bapuji et al., 2012; Stiles et al., 2015). Returning to Pentland & Feldman (2008), these authors argue that only altering its ostensive dimension is prone to failure. Simultaneously, deliberate routine change requires performing the proposed routines. As my findings indicate, such performing implies a gradual shifting from the enacted routines towards the proposed ones so that the emerging routines associate with both meaning structures. This association with the meaning structures is both a matter of understanding the routines (their ostensive dimension) and their enactment in practice (their performative dimension). Because changing routines deliberately requires shifting both dimensions at the same time, reflection becomes essential to observe this process collectively.

Third, I complement the insights that changing routines require collective reflection (Howard-Grenville, 2005). Collective reflection includes experimenting with new routines and learning as a non-routine action throughout the change (Edmondson et al., 2001; Rerup & Feldman, 2011). Scholars have shown how routinized reflection supports to move an organization forward (Adler et al., 1999; Bresman, 2013). My findings contribute to how reflective routines become established. While the establishing process was integral to a temporary initiative, the continued practice of reflective routines fosters ongoing development and stabilization. After all, “routine is both the building block of stability and also the foundation of adaptation” (Feldman & Rafaeli, 2002: 328).

6.5 Summary: Venturing change through reflective routines

This chapter explored the establishment of reflective routines as part of a deliberate change initiative of a nursing unit within the context of the hospital integration. Thereby, I addressed my third research interest on how change unfolds in a pluralistic organization given its paradoxical foundation.

This research interest corresponds to the current issue in paradox literature on how to embed paradoxical solutions within an organization. While reflection is central to envision paradoxical solutions and is usually attributed to the responsible senior or middle managers, the routine dynamics literature helps to extend reflection to those organizational members who are supposed to alter their work routines. Focusing on the establishment of reflective routines throughout the change initiative led to the insight that reflective routines are both a medium and part of the outcome of the change initiative. As part of the outcome, reflective routines become differentiated on different topics, participants, and temporal rhythms, creating expectability of daily work and reaching out to all nursing employees. Thereby, reflective routines support both stabilizing the daily work while engaging the organizational members in its change. As a medium, reflective routines become established through a varying pattern of individual observing, repeated interaction, immediate support, and embedding by formal declaration as well as documentation and their distribution to the hospital. These are the components of the model routinizing reflection and foster collective reflection.

The empirical insights offer four contributions to the paradox literature. First, the model of routinizing reflection depicts the pattern by which a paradox solution becomes embedded within the organization. Second, reflective routines, which are integral to this process, resonate with both of the initially opposing meaning structures in order to handle this paradox. Over time, the association tends to shift towards the proposed meaning structure. Third, the establishment of reflective routines overcomes the separation between the responsible designers of paradox solutions and the implementers. Fourth, I find that embedding paradox solutions occurs as a simultaneous process of designing and implementing rather than as a sequence.

7 Conclusions: Stabilizing and changing a pluralistic organization

"Problems that are never solved are never solved because managers experiment with everything except with what they themselves do and think. When people try to change their surroundings, they have to change themselves, their own thinking and acting – not someone else." Karl Weick (1995: 219)

The three empirical chapters 4-6 report on the research interests explained in chapter 1. These interests focus on research questions for the paradox lens by means of routine dynamics (chapter 2) and draw on longitudinal research of different change initiatives within a single organizational setting (chapter 3).

This last chapter starts with a summary of the contributions offered primarily to the paradox literature, but also to that of routine dynamics with inspirations to studies on organizational change. Then, I reflect on the assumptions, the research practice and on the limitations of the study that give rise to possibilities for future research. This text concludes with a view on management as orchestrating reflective routines within an organization and within management itself.

7.1 Three empirical research interests and their contributions

In this research, I explored pluralistic organizations through a paradox lens and routine dynamics. The following sub-sections contain the summary of the insights on these organizations' improbability, stability, and change.

7.1.1 The improbability of pluralistic organizations: Founding paradox

Following my first research interest on the improbability of pluralistic organizations leads to the insight that a pluralistic organization such as a hospital is founded on the paradox of differentiation and integration (chapter 4). Differentiation notes the plurality of the clinics and departments. Integration points to the organization-wide issues that concern the pluralistic organization beyond the boundaries of clinics and departments.

The paradox lens states that plurality involves paradox because an organization's sub-systems are both independent and interdependent (Clegg et al., 2002; Ford & Backoff, 1988; Lewis & Smith, 2014; Luescher et al., 2006; Smith & Lewis, 2011). Thus, this theory assumes that paradoxes are integral to organizations. Empirical studies often highlight the tension between these sub-systems. They attend to the contradictory contents, but they explore less the ways of acting or organizing through which these tensions are reproduced so that the sub-systems and the resulting paradox persist. Routine dynamics offers an approach to this niche. Routine dynamics allows depicting an organization's sub-systems as meaning structures and to research their ways of acting in association with the members' organizational understandings.

Comparing the meaning structures of three different disciplines – surgery, inner medicine, and nursing – helps to explain why each pursued the organization-wide initiative of integrating their clinics or their department differently. Also, the comparison shows that the three meaning structures differ in their ways of acting, that is, in terms of who becomes involved on what issues, how, and when. Furthermore, their comparison reveals three similarities that indicate how a meaning structure reproduces itself within a pluralistic organization. Each discipline gives priority of treatment work over other topics, transfers ways of acting in patient treatment to organizational issues, and reinforces these patterns by means of their reflective routines. These similarities help to explain endogenously how a meaning structure accomplishes stability. Finally, the organizational members are aware of their organization's plurality and of the need to jointly handle organization-wide issues. In other words, they note the paradox of differentiation and integration. Both of these poles are essential for the studied hospital. In summary, these insights lead me to conclude that the studied hospital is founded on the paradox of differentiation and integration.

These insights contribute three aspects to the paradox literature. First, depicting the ways of acting contributes to a processual view within the paradox lens (Abdallah et al., 2011; Clegg et al., 2002; Jarzabkowski et al., 2013; Jay, 2013; Luescher et al., 2006). It adds *how* the diverse interests and understandings are enacted to our knowledge *that* the diverse interests and understandings characterize plurality. The enactment of plurality expresses the knowledge-intensive work of a pluralistic organization that lies at the core of its activities. In other words, differentiation is essential for these organizations.

Second, the similarities between the meaning structures shed light on how the differing sub-systems reproduce themselves endogenously and accomplish their stability. The three similarities illuminate on how a meaning structure becomes internally coherent, thus adding to the insight that such sub-systems appear logical within (Lewis, 2000). The actively accomplished stability of the meaning structure helps to explain how the differentiation persists within the organization, thereby complementing the core assumption of the paradox lens that paradox are integral to organizations (Lewis & Smith, 2014; Smith & Lewis, 2011).

Third, integration becomes increasingly important and the organizational members are therefore aware of the paradox. The paradox of differentiation and integration is constitutive to this pluralistic organization (Jarzabkowski et al., 2013; Lawrence & Lorsch, 1967). This thought invites us to reconsider the paradoxes on the individual, group, and organizational level the literature has identified as related to or as expressions of the founding paradox.

The research of chapter 4 also speaks to routine dynamics literature. It extends routines to a pluralistic setting, thereby contributing to the rising interest on how organizational understandings and routines relate in a mutually constitutive way (Feldman, 2003; Parmigiani & Howard-Grenville, 2011; Rerup & Feldman, 2011). Making use of meaning structure (Hernes, 2014) while drawing on the distinctions of central and peripheral routines as well as meta-routines (Adler et al., 1999; Gersick & Hackman, 1990) provided helpful guidance to capture the dynamic inter-relations between routines and the organizational understanding they express and draw on.

Addressing the improbability of pluralistic organizations with a paradox lens enriched by routine dynamics, my first insight is that the studied hospital is founded on the paradox of differentiation and integration. While this insight is limited by a single case, the literature suggests that it might apply to other organizations that operate self-referentially. As quoted initially in chapter 4, the German sociologist Dirk Baecker (in von Foerster, 1994: 21, my translation) notes: "*Self-referentially operating systems cannot only avoid paradoxes …, but they also produce them continuously*."

7.1.2 Stabilizing: The duality of the paradox and the coordinating routine

My second research interest is on how a pluralistic organization achieves stability given its paradoxical foundation. This research interest results from the observation that a pluralistic organization such as a hospital appears impermeable to deliberate change attempts. This research interest leads to the insight of an empirically identified coordinating routine that helps to unfold the foundational paradox within the studied hospital. The coordinating routine exemplifies a both-and solution to the paradox of differentiation and integration while making it latent in settings like the executive board. By referring to one another, the paradox and the coordinating routine form a duality.

Building on dynamic (Andriopoulos & Lewis, 2009; Jarzabkowski et al., 2013), processual (Abdallah et al., 2011; Jay, 2013), and relational (Clegg et al., 2002) approaches, I address in chapter 5 the assumption of paradox latency that is essential for the paradox lens but that is not well studied. The literature on the coordinating quality of routines guides the empirical research (Dionysiou & Tsoukas, 2013; Feldman & Rafaeli, 2002; Jarzabkowski et al., 2012; Ockhuysen & Bechky, 2009).

Attending to the executive board within the hospital, my research shows the informal routine of “bilateralism”. It coordinates the different meaning structures and their representational actors who work through the organization-wide issue of integrating two hospitals. “Bilateralism” helps to handle the plurality of interests and perspectives while avoiding open conflict. The coordinating routine provides a both-and solution to the paradox of differentiation and integration. It helps to pursue issues that span the boundaries of the clinics and departments while acknowledging their respective autonomy. Furthermore, the coordinating routine achieves paradox latency. Potential or actual conflicts are transferred from the executive board to private conversations, to projects, or are left unresolved for the time being.

These empirical insights contribute to the paradox lens in three ways. First, the identified coordinating routine depicts a both-and solution to the founding paradox that is enacted in a way that emerges as part of local and situative practice (Clegg et al., 2002). This prior solution marks the specific context to act on the paradox (Beech et al., 2004), to work through and envision new solutions (Luescher & Lewis, 2008), and to implement them (Abdallah et al., 2011; Jarzabkowski et al., 2013; Smith, 2014). My findings

complement these studies by highlighting that attempts of deliberately handling paradoxes need to weave into the existing solution (Langley & Denis, 2006).

Second, accomplishing latency of the founding paradox is integral to the coordinating routine which contributes empirical insights to substantiate the assumption of paradox latency (Lewis, 2000; Lewis & Smith, 2014; Smith & Lewis, 2011). As paradox latency is an accomplishment and not a given, the paradox may be salient to the individual members but latent within settings, for example, of the executive board. Furthermore, my findings illustrate how paradox latency contributes to the stability of a pluralistic organization when it shields the enacted solution from deliberate change attempts.

Third, the founding paradox and the coordinating routine form a duality. The paradox requires the coordinating routine. At the same time, the coordinating routine draws on the paradox of differentiation and integration. The duality of the paradox and the coordinating routine specifies the pervasive yin and yang metaphor often used in the paradox literature (Lewis, 2000; Smith & Lewis, 2011).

For routine dynamics, the empirical insights on the coordinating routine also offer benefits. My research provides an example of how a routine relates different meaning structures. It thus extends routines as a way of coordinating actors (Dionysiou & Tsoukas, 2013; Feldman & Rafaeli, 2002) and different routines within a single meaning structure (Jarzabkowski et al., 2012; Ockhuysen & Bechky, 2009) while attending to the relation between organizational understandings and routines (Feldman, 2003; Rerup & Feldman, 2011).

The insight on a coordinating routine that handles the tensions of differentiation and integration of the founding paradox offers a perspective of how a pluralistic organization accomplishes stability. Thereby, I address the call of Hilary Putnam (1986:166) quoted at the beginning of chapter 5: *"With continued research, perhaps we can discover how organizations pull themselves out of the self-made quagmires by their own bootstraps"*.

7.1.3 Establishing reflective routines in a pluralistic organization

The third insight is that establishing and adapting reflective routines enables an organization to relate two opposing meaning structures and move a change initiative forward. This insight concerns the third research interest on how deliberate change can

unfold in a pluralistic organization, noting that many empirical studies on hospitals often report failure besides successes (see chapter 1).

Likewise, scholars of organizational paradoxes currently note the challenge of organizations to embed paradox solutions within the organization and beyond those who envision that solution (Jarzabkowski et al., 2013; Jay, 2013; Luescher & Lewis, 2008; Smith, 2014). Building on the central importance of reflection in paradox literature, routine dynamics argues that reflection extends to all organizational members (Feldman, 2000; Feldman & Pentland, 2003).

The empirical investigation into the initiative of changing the nursing department as part of the overall hospital integration reveals how reflection is routinized as both a medium and an outcome of the change initiative. As an outcome, the adapted and newly established reflective routines reach out to the organizational members and enable them to systematically observe their daily work and the changes thereof. These observations and their temporal rhythms help to stabilize while changing the department. At the same time, the reflective routines resonate with both meaning structures. This double resonance fosters their establishment. As a medium the establishment of reflective routines moves from the individual to the collective level. The immediate support of emerging issues reinforces the acceptance of the reflective routines that result from ongoing observation and emerge with repeated interaction. Furthermore, the routines' formal embedding as part of the department's structure and the distribution of the reflection contents help to move the change initiative forward. The model of routinizing reflection proposed in chapter 6 summarizes these insights.

The model of routinizing reflection advances the paradox lens in four respects. First, the model shows how reflective routines emerge within the organization and thereby complements the acknowledged importance of reflection when handling paradoxes (Jay, 2013; Luescher & Lewis, 2008; Smith, 2014; Westenholz, 1993). The model bears similarities with "relational spaces" (Kellogg, 2011) by reaching out to organizational members to relate and coordinate their activities and perspectives. Routinizing reflection differs in that reflective routines are orchestrated as part of the change process and formalized to establish them as permanent means to foster the systematic self-observation within and the continuous development of the organization.

Second, the model depicts that reflective routines resonate with both meaning structures. The double resonance helps to weave the proposed meaning structure into the existing one. My model complements the literature that relates the poles of a paradox in terms of their content (Abdallah et al., 2011; Andriopoulos & Lewis, 2009; Clegg et al., 2002; Jarzabkowski et al., 2013; Jay, 2013; Smith, 2014). The model also depicts the double resonance in terms of how the reflective routines are conducted. Resonance in the "way of acting" (Jay, 2013: 140) reinforces that organizational members understand the different meaning structures by avoiding contradictions between what is conveyed and how it is conveyed (Baecker, 2005; Putnam, 1986).

Third, reflective routines imply to overcome the separation between those envisioning the solution and those who are expected to enact it. The paradox literature places importance on the senior leaders or middle managers as those responsible for envisioning solutions to a salient paradox (Abdallah et al., 2011; Ford & Backoff, 1988; Luescher & Lewis, 2008; Smith, 2014). This emphasis risks a separation with those who are expected to enact these solutions prompting the challenge of misunderstanding the proposed solution (Barrett et al., 1995; Bartunek et al., 2006; O'Connor, 1995; Westenholz, 1993). The model of routinizing reflection overcomes the separation in that reflective routines deliberately reach out to the organizational members to design the solutions for their future enactment, thereby avoiding the separation. The model implies that senior leaders orchestrate reflective routines so that the organizational members can envision and enact paradox solutions.

Fourth, as a consequence, I argue that handling paradoxes occurs simultaneously with envisioning its solution. In comparison, the current literature tends to suggest a sequence of first envisioning the solution and then implementing it after the paradox became salient. In this respect, the model of routinizing reflection resonates with improvisation, as argued to relate the paradox of action and structure (Clegg et al., 2002). Planning while you act (Weick, 1993) with the "you" indicating the organizational members suggests that designing and implementing occur simultaneously and adds to sequential albeit cyclical models (Andriopoulos & Lewis, 2009; Jarzabkowski et al., 2013)

The insight of routinizing reflection resonates with Pentland & Feldman (2008), who point out that altering the ostensive dimension of a routine does not suffice for fostering respective routine performance. Routinizing reflection illustrates the dynamic process of

how the change of routines can occur. Furthermore, taking reflective routines into focus builds on the general importance of reflection within routine dynamics (Feldman, 2000; Feldman & Pentland, 2003) and shows how reflection can turn from non-routine action in change (Edmondson et al., 2001; Feldman, 2003) into routine practice itself (Adler et al., 1999; Bresman, 2013; Iedema & Carroll, 2011). More generally, the model of routinizing reflection addresses the call for researching routine emergence (Parmigiani & Howard-Grenville, 2011), building on existing insights that changing routines are related to the organizational understanding (Feldman, 2003; Rerup & Feldman, 2011).

As an outlook and beyond the literatures of routine dynamics and the paradox lens, the model of routinizing reflection may also be inspirational to organizational change scholars. In their seminal work, Weick & Quinn (1999) distinguish between continuous and episodic change. Continuous change means “a series of ongoing and situated accommodations, adaptations, and alterations that draw on previous variations and mediate future ones” (Orlikowski, 1996: 69). In comparison, Langley & Denis (2006: 138) define episodic change as a reference “…to radical, clearly identified and generally deliberate change initiatives that aim to transform the functioning of an organization in a particular way over a condensed time period.” These two views on organizational change are often considered as a dualism but not as a duality (Farjoun, 2010). Accordingly, routine dynamics rather tends to associate with continuous change, whereas paradox studies evoke episodic change. At the same time, Langley & Denis (2006) argue that episodic weaves into continuous change. The model of establishing routines provides an empirically derived specification of this process.

The investigation of how reflection becomes collectively routinized within an organization shows the joint oscillating between action and reflection which is why Barbara Czarniawska (2008: 129) serves as the entrance to chapter 6. *"We know that reflection paralyzes action, but that an unreflected action sooner or later leads to a disaster, so that we need to oscillate between the two ..."*

7.2 Reflections on theory, method, and research

The previous section summarized the insights of the chapters 4-6. Next, follow reflections on the underlying theoretical assumptions before arguing for collaborative research followed by a range of limitations of the empirical research.

7.2.1 Theoretical implications: Self-referentiality and reflection

The insights generated in this research rest on two related ideas: self-referentiality and reflection as observation. First, I argue in chapter 2 to relate paradox literature with routine dynamics based on their assumption of self-referentiality. The literature offers more nuances. The term "duality" involves two components that are complementary albeit potentially contradictory (Farjoun, 2010) often viewed in terms of structuration theory (Giddens, 1984). "Inductive bootstrapping" captures the social creation of reality through self-referentially related structures and events, in which the former label the latter while the latter reproduce or undermine the former (Barnes, 1983). Inductive bootstrapping is similar to a self-fulfilling prophecy (Weick, 1995) and to the duality of communicative event and structure understood as mutually held expectations emerging from observed events (Luhmann, 1984). "Recursiveness" highlights the temporal dimension of actors drawing on previous events as structures when acting in the present (Feldman & Orlikowski, 2011; Tsoukas & Papoulias, 2005; von Foerster, 1984, 1994). In comparison, "mutual constitution" draws attention to self-referentiality in moments of time (Feldman & Orlikowski, 2011; Maturana & Varela, 1980). Finally, "dialectics" (Benson, 1977; Seo & Creed, 2002) associates a thesis and antithesis through a synthesis, the latter of which is not integral to the previous concepts. These different concepts of self-referentiality provide theoretical mechanisms to explain how paradoxes and their handling operate (Farjoun, 2010; Poole & van de Ven, 1989). Future research could further compare the similarities and differences of these concepts to provide scholars with more options for exploring topics like relating continuous and episodic change (Weick & Quinn, 1999), distributed leadership of interacting actors' agencies (Denis et al., 2010), or on accomplishing stability of temporal social orders like organizations (Hernes, 2008; Tsoukas & Chia, 2002).

With the elaboration on self-referentiality, future research could enrich the paradox lens by strengthening a process perspective that is particularly promising for theorizing pluralistic organizations. Based on self-reference, a process view on paradox could consider the paradoxical tensions as well as the self-confirmation in the same theoretical concept of duality. To this end, newer social systems theory (Luhmann, 2000) could provide a promising approach. Here, a paradox is defined as an operation that produces the conditions for its own possibility and impossibility (Ortmann, 2004). Social systems theory thereby draws on duality as bootstrapping and acknowledges both self-

confirmation and self-contradiction (Luhmann, 1990b). For organizational studies, social systems theory highlights that they are founded on paradox and therefore oscillate between invisibilizing and visibilizing the paradox to stabilize and adapt its own ways of acting (Hernes & Bakken, 2003; Knudsen, 2005; Schoenenborn, 2011). Thereby, social systems theory adheres to the interdependence of stability and change as put forth by Farjoun (2010: 203): "both are contradictory yet complementary."

Second, I attend to the core concept of reflection, which I define as a second-order observation taking place on a first-order one (Maturana & Varela, 1980; von Foerster, 1984, 1994). As an observation, reflection is self-referential. It draws on its own understanding that emerges from its process of reflecting. Both first- and second-order observations are active processes of distinguishing and indicating that draw on and thereby enact the distinctions by which they operate.

Elaborating on a process view of reflection provides a promising research area. Reflection is a ubiquitous human activity (Brannick & Coghlan, 2006; Holland, 1999). Reflection pervades organizations as actors perform routines (Feldman, 2000; Feldman & Pentland, 2003), aim to tackle paradoxes (Jay, 2013; Luescher & Lewis, 2008), engage with deliberately changing their routines in relation with their organizational understanding (Feldman, 2003; Rerup & Feldman, 2011), or enact learning (Bresman, 2013) and problem-solving (Adler et al., 1999) routines to continuously advance their organizations. But, our conceptual understanding of reflection is still limited. Zundel (2012) argues theoretically that it is impossible to step out of the process on which one reflects. Similarly, second-order cybernetics emphasizes reflection as self-referential but also invites us to appreciate reflection and the process it observes as symmetrical because both are observations and generate their own blind spots (von Foerster, 1994). Therefore, neither first- or second-order observation is superior to the other or in any sense providing a meta-level (Adler et al., 1999; Lewis & Smith, 2014). A meta-level would require a standpoint from which to draw this distinction. Reflection offers an alternative. It employs a different distinction than the first-order observation it observes. Further elaboration on the relationship between reflection and what it reflects upon would help to illuminate on their entangled relation and their potential to access their respective blind spots in specific contexts (Luhmann, 2000; von Foerster, 1994).

Further development of our insights of reflection as integral to enacting organizations would offer benefits both for routine dynamics and paradox literature. For the latter, we could learn more about embedding paradox solutions when considering collective reflection and thereby overcoming the separation between designers and implementers as I explored in chapter 6. Also, routine dynamics could benefit from further considering collective reflection. First, collective reflection may offer a starting point to further explore the topic of recognizability of routines. Future research could embark on the paradoxical side of routines as patterns in variety (Cohen, 2007; Dionysiou & Tsoukas, 2013) and investigate how a routine is recognized as such. The empirical insights of chapter 5 and 6 provide certain inspirations on the repetition of actions, their temporal expectability, and their addressing certain actors and topics within an organization. I did not explore the recognizability of routines in detail here. Future research could for example provide insights into how in detail mutual expectations emerge over time in specific settings and instances, thereby addressing the call of Dionysiou & Tsoukas (2013) to move beyond their two-actor-model.

Second, exploring both individual and collective reflection in relation could provide insights on the core assumption of agency that both routine dynamics and paradox literature share. Reflection is integral to performing and changing routines (Feldman, 2000; Feldman & Pentland, 2003) and is essential to handling paradoxes (Jay, 2013; Luescher & Lewis, 2008). Reflection therefore lies at the core of agency both individually as people perform routines and collectively: “Individuals act, but they do so in a context created by the actions of the other participants” (Pentland & Feldman, 2003: 104). Attending to reflection may further illuminate this relationship. The empirical insights of chapter 6 may serve as a starting point.

Third, collective reflection is central to deliberately changing routines. The literature reports the importance of collective reflection (Howard-Grenville, 2005) when actors attend to their organizational understanding (Feldman, 2003), engage in in trial-and-error learning (Rerup & Feldman, 2011), explicate taken-for-granted assumptions as they enact their coordination (Jarzabkowski et al., 2012), employ learning (Bresman, 2013) or problem-solving routines (Adler et al., 1999). Building on these works, future research can further explore collective reflection as a means for deliberate change to relate with continuous change (Langley & Denis, 2006; Weick & Quinn, 1999).

7.2.2 Methodological implication: Collaborative research of mutual reflection

In chapter 3, the methodological considerations begin with the assumption that any insight depends on the observer (Jarzabkowski et al., 2014; Maturana & Varela, 1980). Process and interpretive studies (Alvesson & Sköldberg, 2000; Langley, 2009; Sandberg & Alvesson, 2011) are aware of this assumption and view research rather as a generative process than one of discovery (Weick, 1989). Therefore, reflexivity is an established topic. It involves the critical scrutiny of others' or one's own work (Alvesson, Hardy, & Harley, 2008; Alvesson & Sköldberg, 2000; Golden-Biddle & Locke, 1993; Hardy & Clegg, 1997). Reflexivity also extends to the empirical data (Alvesson et al., 2008; Langley, 1999; Lewis & Kelemen, 2002).

Viewed as an observation, reflection implies and suggests extending towards the relationship between researchers and partners in practice (Schumacher, 2015; Tuckermann & Rüegg-Stürm, 2010). This relationship has received less attention, although it is fundamental to generating data (Dutton & Dukerich, 2006) and involves a dynamic process in direct longitudinal research (Barley, 1990; Iedema et al., 2004; van Maanen, 1982).

Reflection takes on the reciprocity between the practice of the research partners and the researchers (Langley, 2009). Each of the two observes the other and themselves throughout the process of research. With their different and distinct orientation either towards science or towards practice, researchers and research partners reflect on each other and themselves (Tuckermann, 2013a). My observational framework takes practice and research as observation and hence in the same conceptual term. Therefore, it helps to address the call for collaborative research in interpretive studies (Balogun, Huff, & Johnson, 2003; Jay, 2013; Luescher & Lewis, 2008; van der Haar & Hosking, 2004) and assists in turning research onto ourselves. Viewed symmetrical, the observational framework offers an entrance to take the double hurdle of scholarly quality and practical relevance (Pettigrew et al., 2001).

Research as a process of mutually observing each other turns into a potentially fruitful endeavor to access one's own blind spots. Practice irritates researchers, and researchers irritate practice with the potential to illuminate what we do not see and that we do not see even that (Luhmann & Fuchs, 1989: 10).

7.2.3 Empirical limitations and implications

Besides the argument for developing and practicing collaborative methodologies for future research, the following limitations point out further options for subsequent studies.

As of chapter 4, a first limitation is that the three meaning structures within one hospital disregard other medical disciplines or administration. Tensions between administration and medicine or nursing have been the topic of various studies (e.g. Doolin, 2001; Iedema et al., 2003; Kellogg, 2011; Llewellyn, 2001; Mueller et al., 2004; Vogd, 2004). While the selected three provide a differentiated view with an invasive and non-invasive medical discipline as well as nursing, other disciplines could generate a more nuanced understanding of the ways of acting and organizing. Their comparison could reveal further mechanisms of how meaning structures reproduce themselves but also provide a more profound validation of the ones identified here.

A second limitation is that the comparison of the three meaning structures regards their internal patterns and does not associate them with social actors outside the hospital. While this focus helps to show endogenous mechanisms of stabilizing a meaning structure, their relations with their respective professional environment could further advance our insights on how professions and disciplines stabilize themselves in particular organizations (Whittington, 2006). Future research could, for example, further explore how clinics and departments relate with professional associations or universities. Both are central for the training of medical doctors, for setting the professional standards in patient treatment, thus showing the recursive relationship between clinics in relation to their hospital and in relation to their respective professional context.

A first limitation of *chapter 5* is the focus on the ostensive dimension of the coordinating routine with the limited display of its performance in specific moments of time. Through the reported incidences of situative and local practice, my results show the mutual constitutive relationship between the founding paradox and the coordinating routine. Furthermore, the data demonstrates the pervasive use of the coordinating routine by drawing on examples and illustrations from other topics. Given the informal nature of the coordinating routines, my results do not explore in detail how the coordinating routine and the founding paradox are means and outcomes to one another over time, for example by displaying a sequence of incidences based on prolonged observation within the same setting. Future research could address this direction and thereby enrich our

insights on how a founding paradox becomes latent while addressing the recursiveness built into the relationship of paradox and coordinating routine.

Second, in chapter 5, the focus is on how a pluralistic organization achieves stability in light of the founding paradox of differentiation and integration by means of an informal coordinating routine. In the research, I followed the practitioners' emphasis on such a pattern and accepted their marginalization of more formalized routines. Future research could extend on the formal routines in relation with the informal ones to gain enriched insights into the stabilizing (or changing) a pluralistic organization.

In *chapter 6*, a first limitation is that the case on establishing reflective routines is on a single department of the hospital. First, in such a setting on the shop floor, there is a direct relationship with patient treatment that appears to provide a favorable condition for establishing reflective routines. This condition appears to result from the fact that patients require attendance irrespective of the circumstances. In comparison, such a relationship appears weaker within the top management team which is remote from the imperative of attending patients. Second, the diverse perspectives are more salient at the executive board level than within a single profession. Future research could investigate further how reflective routines become established between professions and within the top management, thus combining insights from my research with those of Jay (2013).

Second, by choosing the focus of one meaning structure with a direct relation to the patient treatment, the research does not directly elaborate on how the established coordinating routine of chapter 5 alters. Although, the insights on establishing reflective routines shows how such a process unfolds on the shop floor, cases on this topic within the top management are rare. Nevertheless, given the difficulties of organizational members with the established solution, insights on such a process are practically relevant and alternatives to bilateralism could be inspirational for practitioners in other settings. Also, such insights would be insightful to further understand how a solution to a paradox evolves throughout an organization and beyond the common group level of analysis.

Across all three chapters, the boundary conditions apply to this single case study (see section 3.5, pp. 72ff.). The use of different change initiatives and regular and extensive feedback workshops with the organizational members validated our findings internally. Beyond the organizational setting, publications and workshops for practitioners indicated that the findings also resonate with other hospitals in the Swiss Healthcare sector.

Therefore, they bear moderate generalizability, particularly on the general insights that rather concern process than outcome (see Stiles et al., 2015).

7.3 Concluding remarks on managing pluralistic organizations

Beyond these reflections, the concluding remarks address researchers and practitioners. A pluralistic organization like a hospital provides an extreme case. First, the professional practice of different meaning structures is particularly salient in such a setting and emanates to organizational topics, such as integrating clinics, departments, or the entire organization. Second, leaders depend on the consent of the led, which is why hierarchical patterns of decision-making are limited when pursuing organization-wide issues. In these respects, the hospital studied here is special.

At the same time, organizations tend to become increasingly pluralistic (Denis et al., 2007b; Kraatz & Block, 2008). Therefore, this case may serve as a precursor for other organizations that rely increasingly on knowledge-intensive work.

My findings in chapter 4 imply considering the different meaning structures in the research of pluralistic organizations. The meaning structures associate with the professional background and the patient treatment as central to the involved experts. The ways of acting in patient treatment emanate to phenomena that organizational scholars are interested in. Developing strategies (Jay, 2013), changing organizations (Lozeau et al., 2002), budgeting (Jarzabkowski, 2003), merging pluralistic organizations (Denis et al., 2001), or managing innovation (Grand, 2012) become impregnated in a pluralistic organization by the understandings and routines of the knowledge-intensive work that characterize these organizations. Their plurality expresses the improbability of these organizations (Kraatz & Block, 2008), which manifests in the paradox of differentiation and integration. It is timely to acknowledge this movement towards a knowledge society more strongly in organizational studies.

The insights of chapter 5 note that managers operate within plurality and do not act as outsiders separate from the organization (Denis et al., 2001; Wimmer, 2004). In my case, they engage with the established routine that helps to coordinate the diverse understandings, interests, and ways of acting as issues arise. As illustrated in the results, aiming to propose an alternative to the coordinating routine reveals the inescapable self-

referentiality of acting and communicating as part of the organization. Managers work with the coordinating routine if and when they would aim to alter it. In other words, the routines and actions that we label management are part of and embedded in the active accomplishment that we call “organization”. This organization achieves stability and impermeability to (managerial) change attempts because of the self-referential relationship of the coordinating routine with the paradox of differentiation and integration.

In chapter 6, venturing such a change of meaning structures within a single department adapted existing and established new reflective routines. Combining these insights with the ubiquity of reflection suggests approaching managing a pluralistic as orchestrating reflection. Rather than coercively attempting to control otherwise autonomous experts, an alternative is that managing a pluralistic organization attends to the reflective routines within the organization. In terms of a first-order observation, a pluralistic organization performs its core value creation like treating patients. The actors relate with others in a historically established way while mutually acknowledging each other’s relative autonomy. As part of a second-order observation, organizational members individually and collectively reflect on how the organization enacts its own practice continuously (Baecker, 2003). Then, managing within and of the pluralistic organization pursues the task of channeling the ongoing reflection by establishing reflective routines that foster organization-wide decisions to ensure the present and future value creation of treating patients. This view corresponds with Heifetz (1994: 14f) notion of leadership as “influencing the community to face its problems.” Such a reflective approach applies also to leaders, managers and researchers. It invites us to observe, reflect and develop our respective ways of acting. Karl Weick (1995:219) sums up the concluding thought with reference to managers: *"Problems that are never solved are never solved because managers experiment with everything except with what they themselves do and think. When people try to change their surroundings, they have to change themselves, their own thinking and acting – not someone else."*

8 Appendix

8.1 Publications within the Swiss healthcare sector (chapter 3)

Tuckermann, H. & Erk, C. (2015): Strukturierte Kommunikation und Spitalmanagement. ***Imago Hominis*** 22 (2015), Nr. 1, S. 43-54

Tuckermann, H. (2014): Multirational Management in Hospitals. Schedler, K. & Rüegg-Stürm, J. (eds.): ***Multirational Management***, Palgrave: Hampshire: 71-90

Tuckermann, H.; Mitterlechner, M. & Rüegg-Stürm, J. (2014): Weder-Noch": geregeltes Entscheiden mit Systemkontext. ***Schweizerische Ärztezeitung***, 95/19: 751-754

Tuckermann, H.; Mitterlechner, M. & Rüegg-Stürm, J. (2014): Umgangsformen mit der Unmöglichkeit. ***Schweizerische Ärztezeitung***, 95/18: 713-715

Tuckermann, H.; Mitterlechner, M. & Rüegg-Stürm, J. (2014): Zur Unmöglichkeit des Managements von Spitälern: Die Paradoxie von Management. ***Schweizerische Ärztezeitung***, 95/17: 662-7665

Mitterlechner, M.; Rüegg-Stürm, J. & Tuckermann, H. (2013): Das Unwahrscheinliche Managen. ***Schweizerische Ärztezeitung***, 94/27-28: 1094-1097

Tuckermann, H. (2013): Paradoxien von Wandel - Wandel als Paradoxie. Vogel, M. (ed.): ***Die Ausserordentlichkeit von Organisationen***, Hannover

Tuckermann, H. (2012): Management-Entwicklung in Expertenorganisationen. Rüegg-Stürm, J. & Bieger, T. (eds.): ***Unternehmerisches Management – Herausforderungen und Perspektiven***, Bern: Haupt, 113-117

Tuckermann, H. & Rüegg-Stürm, J. (2012): Führung im Spital: Weiterentwicklung der eigenen Führungspraxis auf dem Weg in die Zukunft. ***Swiss Review for Military and Disaster Medicine SRMDM***, 02/2012: 45-52

Rüegg-Stürm, J. & Tuckermann, H. (2008): Warum immer mehr Administration? Wege aus der Administrationsfalle. ***Schweizerische Ärztezeitung*** 89 (7): 271-275

Tuckermann, H. & Rüegg-Stürm, J. (2008): Vom interaktionalen Organisieren zum Organisieren von Kommunikation. ***Schweizerische Ärztezeitung*** 89 (12/13)

Rüegg-Stürm, J.; Tuckermann, H.; Bucher, S.; Merz, J. & von Arx, W. (2008): Management der Vernetzung. Amelung, V. et al. (eds.) ***Vernetzung im Gesundheitswesen – Wettbewerb und Kooperation***, Stuttgart: Kohlhammer, 181-210

Tuckermann, H. & Rüegg-Stürm, J. (2007): Sind Spitäler wandelresistent? Organisieren als Stabilisierung von arbeitsteiliger Wertschöpfung im Kontext fundamentaler Ungewissheit. ***Schweizerische Ärztezeitung*** 88 (45): 1895-1899

8.2 Vignette: Launching “process optimization” at Laho (chapter 5)

The anecdote of launching “process management” at Laho exemplifies how to move an issue forward that lies outside the clinics’ attention and transcends their boundaries. The anecdote conveys several components of bilateralism: raising attention by introducing a concept, subsuming the initiative under other developments, enhancing clinic-driven pilots, and supporting the diffusion of a process orientation with these pilots.

Strengthening a process orientation has been on the CEO’s agenda for the hospital since 2004: “In our board meeting in 2004, we realized that the work hours were too high ... And then, we thought about the consequences. If we raised the number of employees, as usual, that would have been 40 to 50 new assistant doctor positions. Doing that was impossible. ... The only solution was to enhance our processes.” (Hank, CEO of Laho)

First, hospital management tries to raise the attention for process orientation by introducing it as a concept to the heads of clinics and the nursing director. Hank initiates a workshop in the fall of 2005 to discuss the concept of process management with the heads of clinics and the nursing department. He invites a university professor to a one-day workshop to provide first input and foster discussion among the clinic heads. During the workshop, we observe the topic received positively. Hank, the CEO of Laho, is cautiously optimistic: “I think we have started something into this direction”.

Second, hospital management subsumes process orientation under two other initiatives. They include it into the project of enhancing the hospital’s information technology infrastructure, says Damian, the department head of interdisciplinary medical services: “To avoid disruptions, we subsume the process orientation under the IT project and ask: how can we improve work processes through electronic devices? There, everyone thinks, ‘wow, that’s great, let’s do it!’. The idea behind it is of course a little bit different. But you have no chance if you want to sell the idea directly.” With the year of 2006, the new employment law provides another possibility (Merz, 2010). The hospitals are legally required to restrict the work hours of their assistant doctors. This resource restriction helps to place the process orientation under the employment law. Hank, the CEO of Laho, comments: “In the executive board, we knew that just telling the clinic heads to optimize their processes would not work. They just do not think in processes. At the

same time, we need this thinking in the future. This is why we used the employment law initiative to place the topic of processes in the hospital."

Third, hospital management supports clinics' projects to review their processes. To this end, Laho's management restricts hiring but provides financial and conceptual support so that clinics optimize their treatment and administrative processes. Between 2006 and 2007, six clinics conduct projects to solve their restricted human resources (Merz, 2010). These pilot projects are reported to be successful in clarifying tasks and responsibilities, reducing over time for clinicians, and improving the planning of patient flows.

Fourth, in order to foster diffusion among the clinics, the hospital management makes the results of the clinics' process initiatives available to a wide internal audience. With successful pilot examples, Hank launches a workshop for all clinics in which the respective clinics present their projects. In retrospect, Hank considers his approach successful: "I think the willingness has increased both in favor of process thinking and to learn from one another".

8.3 Vignettes: Man-power planning, documenting (chapter 7)

The evolution of the manpower planning and the documenting routine illustrate this interpretation. First, *the documenting routine* is considered important within a professional understanding of nursing to generate comprehensive and timely data on nurse activities. Head nurses and the nursing director need these data for planning, budgeting, and handling different workloads between the wards. Documenting is considered critical within the family understanding in which the nurses give priority to caring. Joan criticizes that the new way of documenting thwarts the core of caring, because it reduces the time with patients. Jill complains that "it keeps me away from the patients". In more general terms, a Henrika (HN-1) observes: "When I work with the computer, my team does not consider that work". Elaine (HN-2) asks: "We are supposed to document everything, in the patient file and in the computer to document our activities more comprehensively and timely so that we do not forget it. But how should I do that in such a bee-house?" The documenting routine remains a difficult issue and is discussed and reported in the head nurse meeting minutes during the year of 2005 in February, April, and June. While the nursing director continues to remind the head nurses to

perform the routine appropriately, the very mentioning of these reminders expresses the teams' difficulties to do so. In November 2005, all but one of the head nurses announces that the documenting of care activities works comprehensively and timely. The head nurses struggle with performing the routines. Elaine (HN-2) explains in an interview in December, 2005: "I have the feeling that I do something and have to document it, again and again. The documenting takes more time than the doing. The whole administrative work is just increasing more and more. All of the team sit in front of computers and write, that is so much more than before". This example of the documenting routine illustrates that the professional understanding becomes part of Reho's nursing with the family understanding still present.

Second, the *manpower planning routine* remains within the family understanding as opposed to the professional understanding: In the former, it is called a wish-list that is oriented to employees' preferences; in the latter, it is a duty-roaster that is geared to the staffing demands of the nursing unit. Manpower planning becomes an issue early during episode 2. In July 2004, Rachel observes a head nurse who "jumps in to do the patient care on the days, when none of her team wants to come because they already have so much over time." For the head nurses, manpower planning is complicated because team members have a lot of over time to compensate, different degrees of part-time contracts, already granted vacation, etc. Ulrika (HN-3) says: "We try to do the man-power planning. But it is quite complicated. All in my team have too much over time, and you also have to respect their family obligations and all. Then we have a lot of part-timers, who I cannot just call and ask them to come." Elaine (HN-2) also the expresses the challenge of man power planning: "I have to do the duty roster now. But many of my team request vacation and there are so many individual wishes. … It is just impossible to plan the month to everyone's liking." Manpower planning remains a daunting issue throughout the rest of the year and during 2005. It is regularly a topic in almost all head nurse meetings, and it is referred to as problematic in several research interviews. During the summer vacation time in July 2005, the wards lack personnel for sufficient staffing so that Rachel requests a duty roster from each ward in September to be revised with her before communicating it to their teams. At that time, Rachel is frustrated: "They just do not get it done, and then we lack personnel. That is especially the problem with the team of HN-3. They just do not get it right, so I do the man-power planning for them" Until the end of the year, manpower planning is not improved on this ward.

8.4 Literature analysis (chapter 2)

8.4.1 Research Question 1

Paper	Building on…	Departing from…
Smith & Lewis 2011; Lewis &; Luescher et al., 2006; Lewis 2000; Ford & Backhoff, 1988	▪ Organizations are complex systems that form subsystems which are in opposition, independent and interdependent with both poles relevant for the organization's success ▪ Paradoxes emerge from self-reference and the poles form a duality.	▪ The literature begins to employ a processual perspective (e.g. Jarzabkowski et al., 2013; Lewis & Smith, 2014)
Smith, 2014	▪ This study explores the paradox of exploration and exploitation and focuses on how senior managers can handle the tensions between these poles. The study generates the insight of inconsistent consistent decision-making, which requires senior leaders to communicate ongoing within the organization.	▪ The different understandings of the involved organizational members regarding exploitation and exploration are mentioned as context in the data (e.g. 1608), but do not enter the resulting model that focuses on how senior managers engage in strategic paradoxes (e.g. figure 2, 1606).
Jay 2013	▪ The study of the Camebridge Energy Association focuses on the process of the top management team reimagining its organizational understandings, thereby providing brief descriptions of the different subsystems such as science, business, and community service.	▪ The general descriptions of the different understandings do not reveal in detail how they accomplish themselves within the organization.
Jarzabkowski et al., 2013	▪ The study highlights the occurrence of different paradoxes which are situated on the individual, group and organizational level and relate dynamically over time.	▪ The different understandings of the involved participants remain under researched
Abdallah et al., 2011	▪ This study reveals the dynamics of managers' engaging communicatively when addressing paradoxes, studied in different organizational settings (art, healthcare, public organization): "action aimed at resolving issues creates new dilemmas that seem to undermine this resolution" (334)	▪ The different meaning structures remain within the context of presenting each case, thus serving as a source of paradox.

Paper	Building on…	Departing from…
Andriopulous & Lewis, 2009	▪ The study explores the paradox of exploration and exploitation that manifests in different other paradoxes all of which are handled through differentiating and integrating practices. The resulting model argues the mutually constitutive, or reinforcing relationship between paradoxes on individual, group, and organizational level (707) ▪ The study shows the tensions between exploration and exploitation triggering paradox salience and inviting managers to act upon them.	▪ The respective subsystems of exploration and exploitation serve as the context within which the focus lies on integrating and differentiating practices employed by managers two relate the opposing poles. These poles of exploration and exploitation are not depicted in detail in how they sustain themselves.
Luescher & Lewis, 2008	▪ The study shows how a group of middle managers engage with their challenges and gain an understanding of paradoxes (see figure 1, p. 228)	▪ The different organizational understandings of the involved participants (the subsystems which they worked in) remain outside the scope of the study
Beech et al., 2004	▪ The study provides a detailed account of a consultant for the NHS to improve cancer treatment and who engaged with hospital managers and clinicians to handle the paradox of centralization and decentralization.	▪ The study reveals the specific tensions that emerged in handling the tensions of centralization and decentralization. The different organizational understandings or subsystems of the involved participants serve as a context from which the tensions emerge.
Clegg et al., 2002	▪ The study argues that organizational subsystems depend on each other (494), by relating the poles of action and structure as duality through improvisation.	▪ The conceptual paper focuses on individual actors and does not take into account the different subsystems.

8.4.2 Research question 2

Paper	Building on…	Departing from…
Smith & Lewis 2011; Lewis &; Luescher et al., 2006; Lewis 2000; Ford & Backhoff, 1988	▪ Paradoxes become salient under conditions of plurality, change, and resource restriction; and when actors emphasize difference over commonalities ▪ The relationship between the poles is dynamic and mutually constituting the poles (Lewis & Smith, 2014: 141)	▪ The dynamics equilibrium model considers paradox latency as a starting condition, but without explicitly elaborating on paradox latency explicitly (Smith & Lewis, 2011: 389)
Smith, 2014	▪ Paradox latency serves as a (theoretical) starting point to position the point of departure that engages with senior managers handling a salient one.	▪ The prior solution remains under explored and does not enter into the conceptualization. ▪ The effect of differentiating and integrating practices on the salience or latency of paradox are outside the scope.
Jay 2013	▪ Ambiguous environmental cues trigger the salience of paradox and the sensemaking process of top management. ▪ Due to the temporal study design, the prior solutions to the paradox are part of the data and the organizational understandings illustrate the relation between the poles of the studied paradox.	▪ Paradox latency serves as a starting point, but without considering the effect of handling the paradox over time on paradox latency
Jarzabkowski et al., 2013	▪ The model offers a dynamic view on inter-related salient paradoxes (265) and on how paradoxes and response patterns reinforce each other to shape the developmental path of the studied organization (figure 2, 265). ▪ Organizational restructuring triggers paradox salience.	▪ The prior solution and the paradox latency are not integral to the proposed model (255, 265). The authors focus on organizational change because these "… contexts offer opportunity to observe salient paradoxes" (251).
Abdallah et al., 2011	▪ The study hints that handling a paradox may involve achieving its latency as the tensions "appear to be dissolved or overcome" (335).	▪ The prior solution to the studied paradoxes remains outside the scope of the study.
Andriopulous & Lewis, 2009	▪ The data hints at paradox latency and the prior solution as "purposeful improvisation" (705) and a "pragmatic idealist vision" (703).	▪ Paradox latency appears implicit within the ways of how the organization enacts the relationship between the poles of exploration and exploitation.
Luescher & Lewis, 2008	▪ Paradoxical inquiry offers a detailed view on how groups of managers make paradox salient for themselves and engage in handling them (228)	▪ Paradox latency serves as a starting point of the model. ▪ The prior solution and paradox latency are not integral to paradoxical inquiry.

Paper	Building on…	Departing from…
Beech et al., 2004	▪ The study embarks on a salient paradox that emerges with a reform to the British health sector.	▪ The data does not illuminate on the prior solution ▪ Paradox latency serves as a starting point.
Clegg et al., 2002	▪ Solutions to paradox are the locally and situatively enacted relation between the poles of a paradox (486) ▪ The relation between poles of a paradox is recursive or mutually constituting or "bi-directional" (489). "When paradoxes are visible the two opposite poles depend on each other" (494) ▪ "Choosing and finding a balance … helps managers to push important dynamics out of the realm of attention" (488)	▪ Paradox latency is a potential outcome of deliberate action, but not considered integral to the relation between the poles.

8.4.3 Research question 3

Paper	Building on…	Departing from…
Smith & Lewis 2011; Lewis &; Luescher et al., 2006; Lewis 2000; Ford & Backhoff, 1988	▪ Either-or: temporal and/or spatial separation or defensive responses ▪ Both-and: integrative responses of confronting, accepting, transcending ▪ The literature tends to prefer both-and approaches, because either-or solutions and defensive responses tend to enhance the tensions and risk vicious circles.	▪ The main focus is on individuals and groups of actors who are responsible for designing paradox solutions, e.g. Smith & Lewis (2011: 388): "Organizations emerge as leaders respond to foundational questions, constructing boundaries that foster distinctions and dichotomies."
Smith, 2014	▪ The study reveals different senior leaders' communicative practices of differentiating and integrating the poles of exploration and exploitation (1610ff.).	▪ Senior managers struggle with engaging employees in newly envisioned paradox solutions (1618). Doing so requires ongoing communication with subordinates.

Paper	Building on…	Departing from…
Jarzabkowski et al., 2013	▪ Handling the salient and dynamically related paradoxes reveals several response patterns, and how these reinforce paradoxes on the individual, group, and organizational level. ▪ The study incorporates the embedding of paradox solutions broadly by sorting response pattern to either embed or not embed solutions within the organization. ▪ The study illuminates on the impact of the response patterns on the organizational change (254).	▪ The study do not explore how such responses like cross-functional teams or interlocking plans between departments emerged over time, despite highlighting the importance of "social mechanisms such as dialogue" (267). ▪ The study argues for implementing settings like cross-functional teams to continuously handle the tensions of paradoxes, but without showing the process of how such settings emerge.
Jay 2013	▪ The study shows the importance of continuous sensemaking (reflecting) that supports envisioning paradox solutions within the top management team (138) ▪ Paradox solutions are intertwined with the organizational understanding.	▪ The study's scope on the top management team does not reveal how the other organizational members enact the emerging organizational understandings.
Abdallah et al., 2011	▪ Managers' handling of paradoxes through communication aims at reframing the situation at hand by means of so-called discourses of transcendence. The study provides a detailed view on the dynamics over time on how such discourses emerge, amplify and end (337). The discourses of transcendence may prove helpful initially but also challenging further on (346).	▪ The focus is on the managers as the actors who handle the paradox, albeit including the organizational responses to these managerial communicative actions.
Kellogg, 2011	▪ The study develops the concept of "relational spaces" by which organizational members relate with, reflect on their organization and coordinate their actions.	▪ Relational spaces emerge from organizational members in response to a dominant group.
Andriopulous & Lewis, 2009	▪ The study reveals integrating and differentiating practices of managers that foster virtuous circles. Thereby managers aim to reframe the tensions to further advance the relation between exploration and exploitation.	▪ The main focus is on the managers who handle the paradox. At the same time, the authors observe (708) that "management also becomes the responsibility of actors throughout the firm."
Luescher & Lewis, 2008	▪ Paradoxical inquiry denotes a process pattern to depicts on how groups of middle managers envision paradox solutions (228) ▪ The study highlights that solutions to paradox are often temporary, or "workable solutions". Also, the study suggests that different paradoxes on the individual, group or organizational level associate with different response patterns (230ff.).	▪ Outside the study's scope is "whether such responses to paradoxes continued and how they affected larger structural changes…" (237)

Paper	Building on…	Departing from…
Beech et al., 2004	▪ Handling the paradox of centralization and decentralization through organizational change, the study argues to view paradoxes as invitations to act. As an invitation the authors suggest "that one actively resists the temptation to achieve intellectually driven closure … and instead pursues the kind of practically driven action that characterizes the behaviors which occur during game play. By adopting this stance, the existence of paradox in problematic situations can be viewed as an invitation to take part in a game in which serious playfulness encourages the actor to engage fully with the sensory, emotional and intellectual dimensions of paradoxical experience" (1323)	▪ While the study detects different response patterns of spatial and temporal separation as well as "synthesis" (1322) between centralization and decentralization, its scope is mainly on the interaction between the NHS-consultant and the hospital management. As the authors note, the initial paradox transformed (1326) into the poles of management and clinical domains, which is not explored further within the studied organizations.
Clegg et al., 2002	▪ Both-and approaches turn the perspective from the poles to their situatively and locally enacted relation	▪ Focused on individual actors, the conceptual paper draws on another study for illustrative purposes.
Denis et al., 2001	▪ The top management team of the pluralistic organization faces many opposing tensions (832) so that stabilizing their constellation becomes an active and ongoing accomplishment (228).	▪ The study calls for "much more attention to the flow of leadership and change throughout the organization" (832)
Lewis, 2000	▪ This study (774) argues for the capacity to "think paradoxically: live and even thrive within the pluralities and changes of organizational life … Building this capacity requires confronting our own defenses…". ▪ It also highlights second-order observation that "entails critically examining entrenched assumptions to construct a more accommodating perception of opposites … Such reframing marks a dramatic change in the meaning attributed to a situation as paradoxical tensions become viewed as complementary and interwoven" (764)	▪ The study highlights different responses to paradoxes. It does not engage with how these solutions emerge and become embedded within an organization over time due to the conceptual nature of the paper.
Westenholz 1993	▪ The study articulates the challenge that a "proponent[s] of paradoxical suggestions… is interpreted on the basis of the existing frame of reference" (54). ▪ Envisioning paradoxical solutions requires learning to think paradoxically which in turn requires possibilities for organizational members to reflect on the tensions.	▪ Hardly explores in depth how communicative settings emerge in which organizational members engage in handling paradoxes.

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9.3 Table of pseudonyms

Fictional names and real functions of organizational members used in direct quotes (others are quoted according to their function):

Name	Function
Hank	CEO of Laho
Nada	Nursing Director of Laho (and Reho)
Torsten	Head of anesthesiology (Laho)

Name	Function
John	Head of surgery (Laho)
Pablo	Head of emergency care (Laho)
Damian	Head of interdisciplinary medical services (Laho)
Sarah	Project manager emergency unit (Laho)
Caitlin	Head of gastroenterology (Laho)
Sam	Head of the center for palliative care (Laho)
Gustav	President of the Board of Directors (Laho and Reho)
Gabriel	Head of organization and infrastructure (Laho)
Robin	Head of Finances(Laho)
Martin	CEO of Reho
Perkins	Head internist (Reho)
Paul	Head internist (Laho)
Mathew	Leading internist (Laho)
Tim	Senior physician at Laho’s internal medicine
Margit	Assistant Doctor of inner medicine (Laho)
Rachel	Change agent of Laho, Nursing director of Reho (since 2005)
Hector	Nursing director (Reho) (until 2004)
Anton	Head of surgery (Reho)
Hana	Head of nursing in the department of inner medicine (Laho)
Sebastian	Head of OHN (Laho)
Teodor	Leading surgeon (Laho)
Anton	Leading surgeon (Laho), temporarily responsible for Reho
Kathleen	Senior surgeon (Laho)
Andrew	Assistant Surgeon (Laho)
Ulf	Clinic manager of gynecology (Laho)
Adrian	Radiologist (Laho)
Bonnie	Head nurse in the clinic for surgery (Laho)
Marvin	Senior physician of inner medicine (Reho)
Mandy	Head of nursing in the department of surgery (Laho), and nurse expert for

Name	Function
	Reho
Herbert	Nurse from the surgical clinic (Laho), and nurse expert for Reho
Dolores	Nurse of Laho's surgery
Vivian	Member of Laho's nursing development unit (Laho), deployed to Reho
Henrika	Head nurse of the ward of inner medicine (Reho) (HN-1)
Elaine	Reho head nurse of the ward of private patients (Reho) (HN-2)
Ulrika	Reho head nurse of the ward of surgery (Reho) (HN-3)
Cheryl	Reho head nurse of the ward of orthopedics (Reho) (HN-4)
Melina	Former vice director of nursing (Reho)
Anita	Laho nurse deployed to Reho during Fall 2004 to help out on the wards
Jill	Nurse (Reho)
Joan	Nurse (Reho)

9.4 Table of abbreviations

Abbreviation	Description
CEO	Chief Executive Officer
OHN	Clinic for Otorhinolaryngology, Head and Neck Surgery
HN	Head Nurse
Laho	Large hospital (acute hospital on the level of a university hospital)
Reho	Regional hospital (acute hospital on a regional level)
DRG	Diagnosis Related Groups (since 2012, Swiss hospitals receive revenues according to a diagnosis as a lump sum. Previously they billed all documented activities)

9.5 Tables of professional titles in medical clinics, and nursing

The hierarchical structure of the clinics and the nursing department contain the following:

Medical Clinic (surgery, inner medicine):

Title	Description
Clinic head	Head of a clinic, sometimes also elected head of a department that harbors several clinics. As the head of department, the clinic head is also member of the executive board.
Leading clinician	Subordinate to the clinic head, a leading clinician is a well experienced medical doctor who oversees an area of clinical activity.
Senior clinician	Subordinate to the leading clinicians who holds considerable medical experience and who is often in charge of one ward (inner medicine), or an operational field of incisions (surgery).
Assistant doctor	Subordinate to the senior physician, the assistant doctor is in professional training to receive is specialty, a process that takes 4 to 5 years in average.

Nursing department:

Title	Description
Nursing director	Head of the nursing department, member of the executive board.
Head of nursing at a clinic	Subordinate to the nursing director, a head of nursing of a clinic leads the nursing unit within one clinic. In case of inner medicine, the head is member of the clinic's management board.
Head nurse	Subordinate to the head of nursing at a clinic, the head nurse is responsible for her team that runs a ward. The head nurse holds considerable experience in nursing and is trained on management topics (at Laho).
Nurse	A professional nurse fulfilled 4-5 year of training, and increasingly holds a degree of a universities of applied sciences (Fachhochschulen). Often professional nurses hold a specialization, as for example in intensive care, emergency care, but also on general wards like on wound treatment.
Nurse developer	Subordinate to the nursing director, nurse developers at Laho form a unit that is concerned with new developments in nursing, and on continuously adapting caring routines throughout the hospital.

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